CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

20/27 December 1997

Milburn's seasonal cheer over money

Private dispensing fee disparity highlighted

Oldham Co-op out of hours service refused

Update: COPD – a disease of the airways

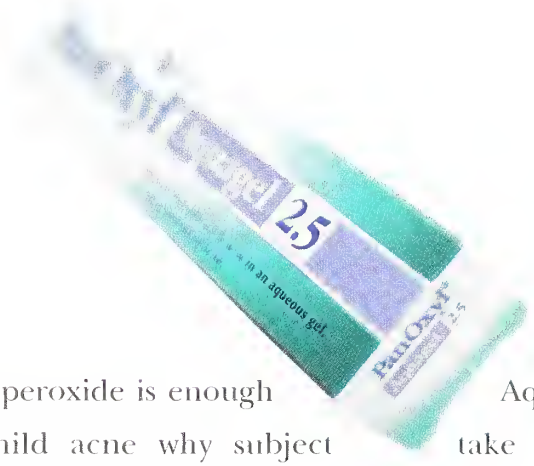
Look back at 1997 in *C&D*'s end of year quiz

Peter Black acquires Ferrosan for £35m

EU gives new rights to part-time employees

Online at http://www.dotpharmacy.com/

Spots can't take it, but young skin can.



If 2.5% benzoyl peroxide is enough to deal with mild acne why subject sensitive young skin to twice or four times that amount? The message is getting through. GPs and dermatologists more and more are prescribing the PanOxyl Aquagel 2.5 formulation. You can take appropriate action by making PanOxyl Aquagel 2.5 the first benzoyl peroxide you think of.†

PanOxyl® Aquagel 2.5
benzoyl peroxide

Appropriate action against mild acne

† In a clinical test, the incidence of irritation was less with PanOxyl Aquagel 2.5% than with the two leading 5 and 10% formulations (Data on File, Stiefel Laboratories Limited, 1996).

Product Information. Presentation: PanOxyl Aquagel 2.5 is an aqueous gel containing benzoyl peroxide 2.5% w/w. **Uses:** For the treatment of mild to moderate acne. **Dosage and Administration:** The gel should always be applied to the affected areas once daily. Washing with soap and water prior to application enhances the efficacy of the preparation. **Contraindications:** Patients with a known sensitivity to benzoyl peroxide should not use the product. **Caution:** Avoid contact with the mouth, eyes and other mucous membranes. **Side Effects:** If excessive irritation, redness or peeling occurs, stop using the product and consult a doctor. **Legal Category:** P. **Retail Price:** 40g £3.10. **Product Licence Number:** PL0174/0049 **Product Licence Holder:** Stiefel Laboratories (UK) Ltd, Hollspur Lane, Woodburn Green, High Wycombe, Bucks, HP10 0AU. **Date of Information:** October 1996.

STIEFEL

Health minister Alan Milburn has reportedly acknowledged that pharmacy contractors got a bad deal in this year's pay round, and is looking to make amends (see p4). This is an encouraging note to end the year on, but talk in the Commons lobby is a long way from a sensible offer on the table. There is little doubt that the Treasury will continue to campaign hard against pressure for public sector pay rises higher than the target inflation rate of 2.5 per cent. The three contractor negotiating bodies will need to adopt a flexible approach if they are to capitalise on ministerial sympathies. Given the announcement that GPs in England and Wales are to get £150 million to link them to the NHS Net, and with trials of electronic transmission of prescriptions imminent, the IT avenue is one which could be usefully explored. Money has already been pumped into GP practices in this area in Scotland. Why the apparent reluctance to include community pharmacy within the primary care IT structure?

But who knows what next year will bring? One thing that can be guaranteed is that last week's White Paper will bring further upheavals. With this in mind pharmacists cannot afford to overlook their OTC business. It will be there, and can be developed along with the rest of the front shop whatever the vagaries of the NHS. There are areas, such as baby care, where business is coming back to pharmacies, and these need to be worked on. Independents have access to the promotional tools to allow them to compete, often courtesy of their wholesaler. Despite the pressure on margins the number of pharmacies has remained static during the year, and more than one recent survey has taken an optimistic view of the sector's prospects. So it's all to play for in 1998. It only remains to wish you, our readers, a happy Christmas and prosperous New Year from all at *Chemist & Druggist*.

CHEMIST & DRUGGIST

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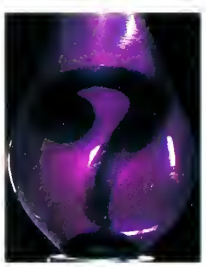


REGULARS

Milburn unhappy over pay deal

Pharmacists have been offered a little Christmas cheer by Alan Milburn, the Health Minister, over the pay deal being negotiated for next April.

The Health Minister has privately told colleagues that he was unhappy about the way in which a 2.4 per cent pay deal was forced on contractors this year, and is seeking ways of enhancing their role.

Mr Milburn has told colleagues that he believes pharmacists have a bigger role to play in the development of the NHS, under the Government's plans for boosting primary care revealed in last week's White Paper.

He is looking at ways of doing more to reward pharmacists, which may mean they could be given a better pay deal from April next year. He may also be able to find development funds to provide incentives for pharmacists to widen their service to patients.

The Treasury is seeking to hold all public sector pay rises in the New Year to its target rate for inflation of 2.5 per cent, but that looks increasingly unrealistic with the retail price index running at 3.6 per cent.

The chancellor reinforced the message to the pay review bodies covering all the other groups in the NHS, including family doctors, with his pre-budget statement. In doing so, Gordon Brown has left the DoH little room in the new round of pay talks which are now getting under way.

Unless Mr Milburn intervenes, pharmacists risk falling further behind, with GPs seeking an extra 10 per cent a year for the next five years, and dentists holding out for the going rate in the private sector of over 4 per cent extra.

The Treasury's determination to keep a tight clamp on public sector pay – in spite of forecasts suggesting the chancellor is heading for a surplus – could mean another year of delays in implementing pay rises after the public sector pay review bodies report to the Cabinet in February.

Other groups, led by the BMA, are saying that the time has come to dig in their heels for higher pay. There will be many competing bids, and health ministers are keen to avoid extra resources going into pay rather than patient care. But pharmacists appear to have got their message across to Mr Milburn.

Keep Pill free call

The Birth Control Trust has expressed fears that prescription charges for contraceptives may be introduced and is asking pharmacists to write to their MP's.

The Trust understands that the introduction of fees for contraceptives is one of the options being seriously considered by the DoH in its review of prescription medicines costs. Concern was raised in June when the DoH would not rule out the possibility that charges may be introduced for pensioners (*C&D* June 14, p5).

An Early Day Motion (EDM 526 Free Contraception) has been signed by 30 MPs. It says: "... that this House believes that free contraception should continue to be available on demand ... so that men and women can continue to plan their families and promote reproductive health".

BCT spokesman David Nolan says that EDMs are a means of flagging up issues. Once there are 100 MPs' signatures, the government is then obliged to consider the issue.

The Trust, which launched its campaign on Wednesday, can be contacted at 16 Mortimer Street, London W1N 7RD. Tel: 0171 580 9360.

Premises fees up

The pharmacy premises registration fee goes up from £128 to £131 on January 1 (up £2 to £71 in Northern Ireland). Annual retention fees increase from £82 to £84 (up £2 to £66 in NI), while the penalty for failure to pay retention fees increases from £264 to £270 (up £3 to £202 in NI). The changes are made under the Medicines (Pharmacies) (Applications for Registration and Fees) Amendment Regulations 1997.

Scottish payments under scrutiny

The Accounts Commission for Scotland has begun a review of the country's pharmaceutical and dental payment systems.

The review follows concerns within the NHS that audit procedures may be inadequate after a series of fraud cases and audit reports in England and Wales.

It aims to enhance the prevention and detection of fraud, and to examine the cost effectiveness of further computerisation and streamlining procedures. The review will track scripts from the surgery to when they are paid for by health boards.

The Scottish Pharmaceutical General Council has agreed with the Accounts Commission to co-operate during the course of the six-month review.

NHS figures out patient confidentiality

Recommendations for patients' NHS numbers to be used to protect confidentiality have been accepted by the Government and new transfer systems for prescription data will be designed.

The 16 recommendations are made in a report reviewing the non-clinical use of personal health information in the NHS. Both the government and the British Medical Association have welcomed them.

Led by Dame Fiona Caldicott, of Somerville College, Oxford, the study aims to ensure that patient identifiable information is only transferred for justified purposes, and that only the minimum information is transferred. It is recommended that the NHS number should replace other patient identifiers where practicable.

The committee has identified 86 ways in which patient identifiable data was transferred and other recommendations include:

- appointing a senior person, preferably a health professional, in each health organisation to be responsible for safeguarding patient confidentiality.
- developing protocols to protect the exchange of patient identifiable information between the NHS and non-NHS bodies
- strict protocols should define who is authorised to gain access to patient identity
- where particularly sensitive information is transferred, encryption methods or other privacy enhancing technology must be explored.

Competition launched by No Smoking Day charity

Anti-smoking charity No Smoking Day has launched a competition to find the pharmacy offering the highest standard of smoking cessation support in the UK.

In January, the Pharmacy Healthcare Scheme will distribute free No Smoking Day 1998 materials to all UK pharmacies, including details about the best practice competition.

The winning pharmacy will receive a £100 gift voucher and a No Smoking Day certificate of commendation. Ten runners-up will receive certificates and NSD T-shirts. For more details contact: 0171 916 7556.

Update: your New Year resolution

Make a commitment to your continuing professional development in 1998 and sign up for *C&D's* **Pharmacy Update** now.

Having been held at £12.50 for the past two years, the charge for enrolling with the telephone marking service will rise to £15 plus VAT next year.

However, subscribers can still sign up at the old rate until January 30. To enrol, simply send your details and a cheque for £12.50 plus £2.19 VAT to Cynthia Anderson Doble at *Chemist & Druggist*, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW. For more details call 01732 364422 ext 2269.

Pharmacy Update has delivered over 30 College of Pharmacy Practice accredited distance learning modules this year providing over 35 hours of continuing education – more than any other pharmacy publication.

Pharmacy Update offers busy pharmacists an ideal method of keeping abreast of the latest clinical and practice developments. It is wide ranging, accessible and versatile.

Each month's learning modules are backed up by a self-test question paper. Pharmacists who sign up for the telephone marking service are provided with independent verification of their work – important if you need to provide evidence of your learning commitment.

A faxback service operates on 0891 444791 for learning modules and their associated question papers (premium rates apply). Update modules and question papers can also be accessed on the *C&D's* **dotPharmacy** Internet site at: *http://www.dotpharmacy.com*

GENUS PHARMACEUTICALS

Next year **Genus Pharmaceuticals** will be demonstrating its commitment to community pharmacy and will be supporting the monthly **Pharmacy Update** question paper. Genus, a subsidiary of Wyeth Laboratories, has in its first year already gained a name for itself as a provider of training courses.

Director Colin Darroch says: "Genus saw the educational benefits coming from Pharmacy Update as something we could be part of. It is very much in line with the company's philosophy and strategy for the future."

Private dispensing disparities

Differences in dispensing fees of £75 for the same item have been highlighted in a letter to the *British Medical Journal* of December 13.

Members of the Research Institute for the Care of the Elderly in Bath spoke out against the large variations in private prescription charges for donepezil, the Alzheimer's treatment.

Researchers contacted 62 pharmacies in and around Bath, and discovered pharmacists charged between £68.32 and £120.41 (mean £98.66) for a 28 x 5mg tablet pack, and between £95.76 and £168.78 (mean £139.18) for a 28 x 10mg tablet pack dispensed privately.

The NHS cost for a month's supply of 28 x 5mg tablets is £68.32, and £95.76 for 28 x 10mg tablets. In general, researchers found that independent pharmacies quoted the lower prices.

"Pharmaceutical Society guidelines, which suggest a 50 per cent mark up on the actual drug price plus a dispensing fee, seem more applicable to the pricing of wine by top restaurants than to the health needs of patients with dementia. Such profiteering is surely unacceptable," says honorary consultant geriatrician Roy Jones.

The RPSGB's head of public relations, Beverley Parkin, plans to contact the institute to point out the RPSGB's position. Currently, it is not permitted to issue guidelines on the scales of fees for private prescriptions.

However, she added, the Royal Pharmaceutical Society is asking parliament for pharmacy to be exempted in the Competition Bill, on the basis of sparing patients confusion, to allow it to give members guidance on pay scales for private prescriptions. The latest representation was made at the end of September.

Christmas excess

The public are being directed to pharmacists for advice on countering Christmas excesses and avoiding problems when driving

As part of a Royal Pharmaceutical Society campaign, an article on how pharmacists can advise on avoiding the feelings of overindulgence – such as drinking plenty of water and taking regular exercise – is expected to appear in the *Daily Mail* on December 23.

In Northern Ireland, people are being told to "avoid the three Ds – drugs, drinking and driving. It can be a deadly combination".

The Pharmaceutical Society of Northern Ireland says a 1994 survey suggested that as many as 760 people a year are killed in traffic accidents caused by the sedative effects of antidepressants.

The PSNI is warning of the dangers to drivers of tranquillisers, sleeping tablets and certain OTC remedies, especially when combined with alcohol.

NHS plans for pharmacists in Scotland

One role of the new primary care trusts, to be set up in Scotland from April 1999, will be "to develop the role of community pharmacists, dentists and ophthalmic opticians in providing high quality care to patients as part of the primary care team".

A White Paper, 'Designed to care', which outlines Scottish Office proposals for the NHS in Scotland, says that these professions "provide essential services, and access to their skills and professional expertise can greatly enhance effectiveness".

The Government has no plans to change the independent contractor status of family health service practitioners, but thinks it is important for them to be involved in the design of patient care "and that the contribution they make is supported within a cohesive framework".

The trusts will be responsible for all primary care, including community hospitals and mental health services, as well as GPs who will group together as voluntary local health care co-operatives. GP fundholding will end by March 1999 and the co-operatives will provide services to patients within an identified level of resources, including prescribing expenditure.

GPs will be able to develop extended primary care teams including nurses and other professions. Those who do not wish to join a co-operative will be given a notional budget for prescribing and their share of cash-limited medical services. A second type of trust will be responsible for a defined set of hospital services within the geographical boundary of health boards.

The government is proposing local flexibility across drugs and hospital budgets. From April 1999 health boards will have a single stream of funds, covering hospital and community health services and GP prescribing.

Drug recall

Seton Healthcare Group is recalling its Adult Meltus Chesty Cough with Decongestant Linctus, batch number P187 and November 1999 expiry, because industrial methylated spirit was used as an excipient instead of ethanol. The class 2 drug alert was issued last Friday. Further details are available from Phil Davies at Seton on 0161 652 2222.

Scottish stats ...

There were 4,473,758 prescriptions dispensed in Scotland in September, 4,465,155 by chemist contractors, at a total cost to the exchequer of £43,862,757. For chemist contractors, the ingredient cost per prescription was 877.19p with a professional allowance of 40.78p and oncost of 0.17p. The gross total per prescription was 1023.56p or 969.12p net.

... and NI stats

There were 1,792,671 items dispensed from 1,079,658 prescription forms in Northern Ireland in September. The ingredient cost was £17.90 million (£16.76m net). The discount £1.147m, with oncost and other payments totalling £2.878m. The gross cost was £19.63m (£19.08m net). Gross cost per prescription was £10.9523 with ingredient cost £9.9868. The net ingredient cost per prescription was £9.3470.

Premises up again

The number of registered pharmacy premises rose in November for the fourth month running. The net increase was 19, bringing the total number of pharmacies in the UK to 12,302, the highest since last December's 12,325. Forty pharmacies commenced trading, 22 were deleted and one was restored.

BP 1998

The Stationery Office has announced that the British Pharmacopoeia 1998 and British Pharmacopoeia (Veterinary) will be published in March, coming into effect on December 1, 1998. The BP will include 120 new monographs and a CD-ROM . The price is £595. The ISBN is 0 11 322100 2.

Chemist & Druggist

The *C&D* office will close from December 25 until January 4, 1998, inclusive. The next issue will be published on January 3 and will be combined with the Price List. Happy holidays!

Out of hours contract refused

United Norwest Co-op's application for an out of hours pharmacy contract at an Oldham health centre has been turned down.

Sainsbury's pharmacy in Denton, ten miles away, objected to the application at the Go to Doc medical centre in Yates Street, Oldham. The Health Services Appeals Authority expressed sympathy with the application, but upheld the appeal because its interpretation of the regulations was that a new out of hours contract could not be granted.

John Nuttall, operations manager of the Co-op's Health Care Division, said it was an extremely disappointing decision, coming at a time when the Government was trying to reduce health service bureaucracy.

"We have not given up on this and we are hoping to pursue other avenues. It seems totally inappropriate that a pharmacy in Denton should be able to affect an important service in a town ten miles away," he said.

West Pennine HA is to write to the health secretary to ask for the regulations to be updated. William Greenwood, assistant director primary care, said: "Given the distance involved, no-one can understand why this particular pharmacy objected. We are trying to develop new services and we thought the proposed new pharmacy contract was in the best interests of patients."

A spokeswoman for Sainsbury's told *C&D* that the health authority invited the company to participate, in the belief that the Denton pharmacy would be affected by the proposals. "Our concerns were supported by a number of pharmacies more local to the site," she added. Sainsbury's pharmacies are already open for long hours.

Go to Doc out of hours medical co-operative serves 170,000 patients and is run by 84 West Pennine doctors. The pharmacy service would have been open to these patients and to others outside the scheme. Dr Brian Lewis, one of the founders, intends to raise the matter with local MPs.

United Norwest Co-op has the option of applying for a judicial review of the decision, but a spokesman was unable to comment publicly.

- The National Association of GP Co-operatives, the umbrella organisation for the 20,000 GPs involved in out of hours co-operatives, has written to the health secretary and the Medicines Control Agency seeking relaxation of controls on children's paracetamol mixtures. Chairman Dr Mark Reynolds told *C&D* that it was distressing for patients to have to drive long distances, with a sick child, in search of an open pharmacy. He said pharmacists should do more to organise out of hours services.

Society says: CPD is the shape of things to come

A move away from accredited units of continuing education to pharmacists collecting a portfolio of personal professional activities, may be the way forward for continuing professional development.

These views were expressed at the Royal Pharmaceutical Society's conference, 'Developing together: Sharing a lifelong commitment to CPD' (*C&D* December 13, p5), held last week.

Centre for Pharmacy Postgraduate Education director Peter Wilson thought it was important to identify the learning needs of individual practitioners and for them to devise their own personal learning programmes. This was the direction being taken by other professional groups and being considered in the Departments of Education and Employment, he said.

He rejected the idea of needing employers to enforce a professional approach to learning. Instead, he would like to see the activity and questioning of professional judgement built into 'education packages' to enhance and increase professionalism.

CPPE also plans to address the issue of evaluating the effect of CE programmes. "If we are not evaluating, we cannot show the influences on patient care, then CPD funding is unlikely to continue to be funded."

Scottish director Rosemarie Parr supported the view of collaboration, within the profession and with other professions. She recommended starting intercollaboration and interprofessional education on a small, local scale.

For Wales, WCPPE deputy director Guy Thompson said that there is a need to consider reflective skills.

Terry Maguire set out Northern Ireland's approach, saying the modular approach was a way of overcoming the limits of learning in single sessions.

Latest VAT regulations on aids for handicapped

Regulations coming into effect on January 1 specify when drugs, medicines and aids for the handicapped are zero-rated for VAT purposes. But the National Pharmaceutical Association is still seeking clarification on the implications for community pharmacists.

The VAT (Drugs, Medicines and Aids for the Handicapped) Order 1997 (SI No 2744; Stationery Office £1.10) says that for zero-rating to apply, the items must be "qualifying goods". These are defined as any goods designed or adapted for use in connection with any medical or surgical treatment except hearing aids, dentures, spectacles and contact lenses. The supply is not eligible for zero-rating if the goods are used while a person is receiving medical or surgical treatment or care in, or while attending, a hospital or nursing home.

Items other than medical or surgical appliances and their accessories, incontinence products and wound dressings can be zero-rated when supplied direct to a person in hospital or other institution, when that institution has nothing to do with the supply.

Government gives GPs £150m for computer upgrades

The Government is supporting GPs' connection to the NHS Net with £150 million as part of the health White Paper plan. However, pharmacists are to receive no money for the NHS Net, the DoH confirmed on Tuesday.

The money will pay for the cost of upgrading GPs' computers to a national quality standard and for GPs' connection to the NHS Net.

All computerised GP surgeries will be able to receive some hospital tests over the NHS Net by the end of 1999, according to the DoH.

By 2002, GPs will be able to: access specialist medical advice; share information; book hospital appointments and access a patient's test results more quickly.

The Royal Pharmaceutical Society says the early inclusion of Britain's 12,000 community pharmacies in the NHS Net is vital.

Health action zones to get £4m in 1998 and £30m in 1999

The Government is to provide £4 million to fund Health Action Zones' services in 1998/99 and a further £30m in 1999/00, said the NHS Executive's director of planning Alasdair Liddell last week.

Speaking at an NHS Confederation conference on the proposed HAZs, Mr Liddell highlighted the timetable's tight deadline. Bids for the first wave of between five and ten HAZs must be submitted by January 23 next year.

Successful bids would be announced in March 1998 and set up the following month.

HAZs will be similar in size to HAs and will last up to seven years. HAZ status will be a positive factor in bids for lottery healthy living centre funds. HAZs may be given priority access to Health Service capital, and support with private finance initiative developments.

Special funding to support NHS strategic change may be given if HAZs can show that the achievement of change will reduce the cost of the service.

"The incentives in the system have been reversed so that partnership is at the heart of everything and joint working is encouraged by the framework," said Hugh Bayley, the health secretary's parliamentary private secretary.

Proposals to improve the performance in HAZs include making NHS trusts' boards and chief executives responsible for quality, and the establishment of a new National Institute for Clinical Excellence to give a lead on clinical and cost-effectiveness.

Further measures include a new Commission for Health Improvement to underpin local commitments to quality assurance, and a new performance management framework to analyses outcomes, health gain and patient experience.

Co-operation with the private sector in areas such as estate management, IT, and project management will be encouraged. Barriers between budgets within HAZs will be broken down and contracts replaced.

Targets that HAZs will have to meet are:

- the development of partnerships to deliver local health strategies in the short term
- in the medium term, more integrated care; more care provided in the community; refocusing of the NHS towards health promotion rather than service delivery
- long-term targets include a blurring of boundaries between primary and secondary care; commissioning of services and a more collaborative approach.

INDUSTRY VIEWPOINT

There are ways of tackling shoplifters

While working with one of our sales representatives recently, two pharmacists we visited spoke about the shoplifting problems they faced. It is easy to imagine – kids, or perhaps even adults, quietly concealing an item under their coats and walking out unobserved.

Nothing could be further from reality. In these two pharmacies, the problem was literally organised crime. The pharmacies had been visited in advance so that the thieves could identify the goods they planned to steal. Then one day a burly individual walked unobtrusively into one of the stores, opened a large bag, scooped the promotional shelves clear of stock – and was gone. The next day he returned, this time clearing a Christmas display.

Hundreds of pounds of stock gone in two days. The police were sympathetic, but they explained there was very little chance of identifying the criminals or recovering the stock.

> In these two pharmacies, the problem was literally one of organised crime

Couldn't the staff tackle the thief? A young girl of 18 versus a burly 6ft male – probably not wise.

Regrettably, this is a problem facing all retailers today. While major chains can build sophisticated security into their operations, it is much more difficult for small independents, especially when the pharmacist is busy in the dispensary and the shop is managed by just a few staff.

It was, then, very encouraging to read the interview in *C&D* with Barry Andrew, managing director of Moss Chemists. Moss has decided to grasp the nettle by introducing sweeping security measures into numerous stores.

Hopefully Moss' research and the variety of solutions will be made available to independent pharmacies through Unichem. After all, a problem shared can be a problem solved.

Contributed by a senior industry manager.

Topical Reflections

Little to rejoice over in White Paper

Christmas is normally a politically quiescent time, but not this year with two vitally important sets of papers published in the second week of December.

The first was the long awaited White Paper setting out Labour's vision of 'The New NHS', and the second was a combined submission from the Royal Pharmaceutical Society, the National Pharmaceutical Association and the Pharmaceutical Services Negotiating Committee on the rational distribution of pharmacies.

Having had both these documents land on my desk, and with a busy pre-Christmas weekend in front of me, I was sorely tempted to file them both under 'pending', but they really are too fundamental for such a strategy. They both point the way towards all our futures, and given NHS Executive co-operation those on rational distribution could become milestone documents.

Certainly, I see little scope for rejoicing at the content of the Government's White Paper. Devolving total budget resources to large commissioning groups of GPs and community nurses without any guarantee of pharmacist involvement will almost certainly slam the door on the continuation of all those non-core pharmaceutical services that so many have striven for so long to develop with their local health authorities.

Whereas the White Paper is negative in its aspirations, it also does not propose any major changes for community pharmacy. In fact, it hardly even mentions community pharmacy, which leads me to believe that we are now on our own, with an unsatisfactory contract and a global sum amount that will continue to decline in real terms unless we can reorganise from within. And it is in this area that 'Rational Distribution of Pharmacies' could provide a springboard for the future.

The development of improved pharmacy services has to revolve around available resources, but if the door to new money has been firmly closed, then the money already existing must be made to work more efficiently.

I have no doubt that there are too many pharmacies, but also that a rationalisation of contracts which is accompanied by a fair compensation scheme, and a government assurance that the released resources could be used to develop improved pharmaceutical services, is now an attainable goal.

There is broad agreement between three of our representative bodies on the necessity to retain control over the issuing of contracts, but to reduce the bureaucratic workload for applications (and therefore save the Government money). The need to organise some form of planning framework – I like the idea from the NPA of 'needs assessment' – and to establish a compensation scheme for 'tied in' contractors is recognised.

However, we must first seek agreement in principle from the NHSE that these three elements could be integrated into a ring fenced, global sum-funded rationalisation of pharmaceutical services.

With that assurance, and given the unanimity of opinion already expressed, I am sure the profession could quickly agree on a single policy submission. Then, with the unusual prospect of pharmacy united in its purpose, I could look forward optimistically to a new year.

CHCs need to be realistic

I talk to many people about the problems of the NHS, but invariably when the subject of improved pharmaceutical services is raised, initial enthusiasm is quickly replaced by disinterest as my need for payment becomes clearer.

It is very easy to criticise pharmacists for not providing services, especially when those making the criticisms normally lack any awareness of market economics. An example of this is the ridiculous criticism of Warrington Community Health Council that the GP out-of-hours service is being compromised because no pharmacies stay open late (*C&D* December 13 p5).

The idea of an open-all-hours pharmacy may be laudable to the CHC, but they are not the ones who will fund the service. If a few more public officials understood basic business economics, then pharmacy might receive a lot more understanding.

As it is, I trust that the reply from North Cheshire LPC secretary, Robin Brown, to the CHC is to the point. And while on the subject, he might inquire of their opening hours over the festive season!

COUNTERpoints

Christmas closing times

- **Aurum Pharmaceuticals** will be open during normal office hours (9am to 5.30pm) on December 24, 29, 30, 31 and January 2.
- **Bristol Myers Squibb Pharmaceuticals'** order department will be closed from noon on December 24 to 9am on January 5. Ansafone: 0151 677 2201. Emergencies: 0151 604 2000.
- **Britannia Pharmaceuticals** will close at noon on December 24 and reopen on the 29th. The office will close at noon on December 31 and will remain closed on January 1, 2.
- **CP Pharmaceuticals** will close from noon on December 24 until January 5. A limited service will be available on December 31 and January 2.
- **Dominion Pharma** will close on Christmas Eve and reopen on January 2.
- **Eldon Laboratories'** One Stop Specials Shop will be open on all days except December 25, 26 and January 1.
- **Martindale Pharmaceuticals'** will be closed on December 25, 26 and January 1. It will open from 8.30am to 4pm on December 29, 30, 31 and January 2, and from 8am to 6pm on January 5.
- **Parke-Davis'** Medical Information Department and Elan Pharma will be closed from noon on December 24 until 9am on January 2. An emergency out of hours medical service is available on 01495 762468.
- **Pharmacia & Upjohn** will be closed from noon on December 24 until December 26 inclusive. The office will re-open on December 29. It will be closed on January 1.
- **Smithkline Beecham Pharmaceuticals** will be closing at 12.30pm on December 24. A limited service will operate from 10am to 4pm on December 29, 30 and 31 and January 2.

Nicorette offers an alternative for quitters

Pharmacia & Upjohn has launched the Nicorette Inhalator, a new presentation of nicotine replacement therapy which tackles the physical and behavioural dependencies associated with smoking.

It is recommended for highly behavioural-dependent smokers who smoke up to 20 cigarettes a day.

The Nicorette Inhalator consists of a mouthpiece and a cartridge containing 10mg of nicotine (5mg for inhalation) which is placed in the device. It should be used whenever the person feels a craving to smoke.

The patient sucks air into the mouth through the mouthpiece. The vaporised nicotine can then be absorbed through the mouth's lining.

Each cartridge contains a 20 minute supply of nicotine, although the manufacturer recommends using it for shorter periods of time. For weeks one to eight of the smoking cessation programme, the recommended number of cartridges is between six and 12 daily. During weeks nine and ten the number of cartridges used should be halved until by weeks 11 and 12 the smoker has completely weaned themselves off the nicotine.

In addition to supplying nicotine in smaller amounts than cigarettes and in a safer way, the Inhalator helps smokers break the behavioural habit, particularly the hand-to-mouth movement. Researchers estimate that a 20-a-day smoker repeats the hand to mouth action around 73,000 times in a year.

In placebo-controlled trials the Inhalator was found to reduce the cravings experienced by smokers trying to give up. Those using the Nicorette Inhalator were about half as likely to have urges to smoke, to be impatient and irritable and to have difficulties concentrating, than those using a placebo.

A starter pack consisting of a mouthpiece and six nicotine cartridges in a child-resistant carrying case, retails at $5.95 and a refill pack of 42 cartridges costs $19.95

Pharmacia & Upjohn is supporting the launch with a comprehensive educational package for pharmacists, offering the chance to obtain credit for learning points, as well as workshops. The company has also set up a helpline (0800 2448387 or 0800 2 GIVE UP) which smokers or pharmacists can contact for further information.

Pharmacia & Upjohn Ltd. Tel: 01908 661101.

Warner-Lambert's winter wonderland

Warner-Lambert Consumer Healthcare is investing $250,000 in a merchandising initiative to boost sales of its winter brands in pharmacies.

A motorised window display unit and multi-brand counter unit have been designed for Benylin, Benylin 4-Flu, Calpol and Sudafed.

The eye-catching window unit incorporates two sets of four rotating panels. One set features the pack graphics of each of the brands and the other shows this season's national advertising for each product.

The compact counter unit includes special compartments for varieties of Benylin, Calpol, Sudafed and Elixir.

Warner-Lambert Consumer Healthcare. Tel: 01703 641400.

Vitabiotics eyes up the supplements

Visionace is a new dietary supplement from Vitabiotics which is said to help maintain healthy eyes and good vision.

The formula includes antioxidant vitamins, bioflavanoids and betacarotene which, Vitabiotics says, are important for the health of the retina and lens.

Zinc deficiency can cause functional impairment of the eye and Visionace contains the recommended daily allowance of this mineral.

A pack of 30 capsules retails at $4.95.

Vitabiotics Ltd. Tel: 0181 963 0999.

Whitehall's winter boost for Advil

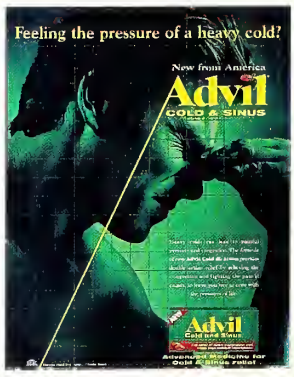
Whitehall Laboratories is investing $1.4 million in a new advertising campaign to drive sales of its Advil Cold & Sinus this winter.

The campaign, which includes TV and press advertising, is designed to demonstrate the efficacy and power of the brand.

The TV commercial will initially be on air in January and will be shown on ITV, Channel 4 and satellite.

It is aimed at busy people who do not have the time to suffer the inconvenience and painful pressure of a heavy cold.

Whitehall Laboratories Ltd. Tel: 01628 669011.



NOW YOU'LL SEE IT WORKING

ALL NEW TV SPONSORSHIP CAMPAIGN

The first ever sponsorship of Regional Weather bulletins on GMTV
4 SLOTS A DAY, 5 DAYS A WEEK, DECEMBER - MARCH

MASSIVE COLOUR NATIONAL PRESS CAMPAIGN

It's no wonder Covonia is Britain's fastest selling pharmacy cough medicine *
With that distinctive taste and warm comforting glow, people are convinced that they can actually feel Covonia working.

And with the massive new campaign, you'll see it working on sales and profits as never before.

ORIGINAL FORMULA COVONIA COUGH MEDICINE

Presentation: Oral Solution. Each 5ml contains 7.5 mg Dextromethorphan hydrobromide BP and 2.5 mg Menthol BP.
Indications: For the symptomatic relief of non-productive coughs such as those associated with the common cold and bronchitis **Dosage and administration:** Adults and children over 12 years old, two 5ml spoonfuls. Children aged 6 - 12 years, one 5 ml spoonful, the dose may be repeated after 4 hours if required. Not recommended for children under 6 years. **Contraindication, warnings, precautions:** Contraindication: Liver disease. Hypersensitivity to any of the ingredients. Patients receiving MAOIs. Persistent or productive cough. **Warnings:** Covonia normally works without causing drowsiness, but care should be taken as rare exceptions can occur. If symptoms persist consult your doctor. Do not exceed the stated dose. Keep all medicines away from children. **Precautions:** Driving - Dextromethorphan may cause dizziness and drowsiness rarely. Cimetidine may delay the elimination of dextromethorphan. **Use in Pregnancy:** No data. However, dextromethorphan and menthol have been widely used for many years without apparent ill - consequence. **Side effects:** Constipation, gastro-intestinal discomfort, nausea, vomiting, dizziness and drowsiness may occur rarely. **Legal Category:** P **Licence Number:** PL 0240/5033 **Date of Preparation:** October 1997 **Pack Size:** 150ml **Price:** 150ml - £2.29 **Licence Holder:** Thornton & Ross Ltd. Huddersfield, HD7 5QH, England

* Nielsen Retail Audit Pharmacies excluding Boots, July/August 1997

Brighter outlook for Wella Colour Mousse

Wella has relaunched its semi-permanent Colour Mousse with new packaging and a fashionable shade range.

The company aims to encourage new users with the updated range which is targeted at fashion conscious 17 to 25-year-old females.

The range now features six shades – Champagne, Savannah, Rosehip, Spice Chilli and Plum.

Retail price is £2.99.

Wella Great Britain.
Tel: 01256 20202.

Cloud of misery

Smithkline Beecham in Ireland has launched a new TV campaign for Beechams Flu Plus Hot Berry Fruits. Running on UTV for four months, the ad uses computer graphics to illustrate the 'cloud of misery' which follows cold and flu sufferers around.
Smithkline Beecham Ireland Ltd.
Tel: 00 353 1 284 5555

Travel vitamins

David Hart is the UK distributor for Jet Ease – a vitamin food supplement developed by NZ Health Products for the long-distance traveller.
David Hart.
Tel: 01992 522123.

Weather link

Thornton & Ross is supporting its Covonia Bronchial Balsam with a £750,000 promotional campaign, including a three-month sponsorship tie-in with the GMTV regional weather service.
Thornton & Ross Ltd.
Tel: 01484 842217.

Conveen relaunch

Conveen Stay Dry Pads will be relaunched as Conveen Multi Action Pads in January.
Coloplast Ltd.
Tel: 01733 392000.

Natural attraction for Corn Silk

Chattem will be supporting its Corn Silk range of powders, foundations and concealer with a £250,000 advertising campaign in 1998.

Starting in March/April, the 'natural attraction' campaign will appear in women's magazines.

New point of sale material featuring the brand's natural looking new model is available.

Chattem UK Ltd.
Tel: 01256 844144.

A Brushtox with the devil

Brushtox antiseptic toothbrush cleaner, which is distributed by Ceuta Healthcare, is being supported by a £220,000 advertising campaign.

Starting in national daily newspapers this week, the campaign will appear in women's and health magazines regularly during the next six months.

Entitled 'Devil brush', the campaign's message is that disease-causing bacteria, viruses and fungi can infect a new toothbrush within two days.

Ceuta Healthcare.
Tel: 01202 780558.

Travellers get fresh

Warner-Lambert is giving out samples of its Listerine mouthwash in a two day campaign at London's Waterloo train station on December 23 and 24. The company aims to give miniature bottles to over 35,000 travellers.
Warner-Lambert Consumer Healthcare.
Tel: 01703 641400.

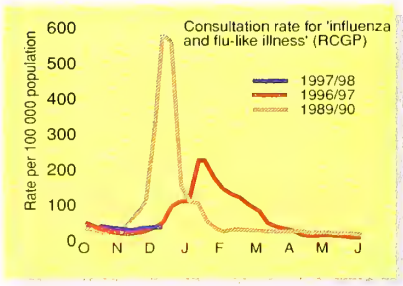
Don't dry up

Colgate Oral Pharmaceuticals has introduced an educational fact sheet to encourage pharmacists to be proactive in giving advice and recommending products to treat xerostomia, or dry mouth.
Colgate Oral Pharmaceuticals.
Tel: 01483 464464.

Flu Monitor

PHLS

Information updated weekly by the Public Health Laboratory Service, London



Summary

The incidence of flu-like illness remains below baseline levels across the UK as Christmas approaches. In the RCGP scheme consultation levels during the first week in December were virtually the same as the previous week at 34.6 per 100,000 population. In Wales, consultations rose slightly to 5.3 per 100,000, still well below the baseline activity threshold of 25 per 100,000. Flu activity also remains low in Scotland. Six influenza A isolates were characterised in week 50, four coming from central England. Deaths from respiratory disease numbered 1,567 in week 49, which is within the expected range for the time of year.

International perspective

The number of confirmed influenza A (H5N1) infections in Hong Kong has risen to six. Two patients have died, but there is no evidence yet of human to human transmission of the virus, which is of avian origin. WHO centres are working to prepare a seed virus in case a vaccine is needed. Across Europe and the US most areas are now reporting isolated cases of flu infection.

Data from the PHLS (Communicable Disease Surveillance Centre, Virus Reference Division, CDSC Welsh Unit), the RCGP and Scottish Centre for Infection and Environmental Health

Nailoid gets results with nail polish remover

Richards & Appleby has launched two new nail polish removers in its Nailoid Results range.

Fast Action Gentle Formula Nail Polish Remover is for natural nails. It has added provitamin B5 to protect the nails and cuticles against splitting and flaking.

Fast Action Acetone Free Nail Polish Remover is for use on artificial nails and tips or natural nails. It has rosemary oil to help condition and smooth nails and cuticles. Both products retail at £1.75 for 200ml.

Richards & Appleby Ltd.
Tel: 01685 843384.

Mudd, Mudd, Mudd glorious Mudd ...

Chattem UK has introduced three new masks in its Mudd Mask range.

The new additions are Mudd Mask Aloe, Mudd Mask Quick and Mudd Mask Sea.

Designed to absorb oil and dirt from the skin, the masks are rich in minerals and trace elements. Each product contains 100 per cent pure and natural clay.

The entire range has also been repackaged. It is being supported by a national advertising campaign in the women's press.

Retail price is £4.39 for 75g.

Chattem UK Ltd.
Tel: 01256 844144.

For ladies' eyes only

Larkhall Green Farm is relaunching its Lipcote lipstick sealant with new packaging and a six week advertising campaign.

The company is spending nearly £100,000 on Admedia 'Eyesite' posters to be put in ladies wash-rooms in 160 shopping centres across the UK.

The idea of the campaign is to capture women's attention as they are fixing their make-up during shopping excursions.

White and red livery replaces the old pale pink packaging.

A more compact counter-display box, which holds six units, has been introduced.

Retail price is around £3.00.

Ceuta Healthcare.
Tel: 01202 780558.

Have handy health booklet, will travel

Just published is a handy new health booklet for overseas travellers.

'What should I do? – practical health advice for travellers' is an A-Z quick reference guide written by UK GPs.

It gives simple medical advice for the traveller on how to deal with a medical emergency abroad.

The full colour, 76 page booklet costs £3.49. The publishers are offering pharmacies a special 'starter pack' of 500 booklets for £1.99 each.

RTFB Publishing Ltd.
Tel: 01703 229041.

ON TV NEXT WEEK

Alka-Seltzer XS: All areas

Beechams Flu Plus: All areas except U, CTV, C4, GMTV

Benylin: All areas

Benylin 4-Flu: All areas

Covonia: GMTV

Day & Night Nurse: All areas except CTV, C4, GMTV

Fetish: All areas

Gaviscon Advance: All areas

Meltus: STV, B, G, C, Y, CAR, GMTV, Sat

Nytol: All areas

Pantene: All areas except GMTV

Prosport: Sat (Sky Sports)

Sensodyne Gentle Mouthrinse: All areas

Sensodyne toothpaste: All areas

Setlers: All areas

Soothelip: C, LWT, M

Strepsils: All areas

Tixylix: All areas except C4

Vicks Sinex: All areas except U & C4

Vicks VapoRub: All areas except U

Vicks New Vaposyrup: GTV, STV

Wella Experience: C4

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Coping with Christmas indigestion

Research by Zantac 75 (ranitidine) suggests that the incidence of indigestion and heartburn increases by five million to a staggering 24 million cases during the festive season.[1] For many of these patients suffering from the effects of Christmas stress and over-indulgence, the pharmacy will be the most convenient source of advice and treatment.

Zantac 75 has the two fastest-selling SKUs in the H2 antagonist sector, with both in the top ten of all OTC indigestion and heartburn remedies.[6] With two-thirds of existing brand sales being accounted for by the largest pack size and the new 24-tablet pack offering the pharmacy staff to maximise their role in the management of indigestion and heartburn.

By recommending Zantac 75 this Christmas, you can give your customers the gift of up to 12 hours' indigestion relief – leaving them free to concentrate on making the most of the festivities.

You can be assured your customers will be pleased that you recommended Zantac 75. Only 30 per cent claim to be satisfied with the duration of relief offered by antacids and alginates.[2] So it is no surprise that Zantac 75, in offering up to 12 hours' relief in a single tablet dose, is considered superior to their previous remedy by nine out of ten customers.[3]

Ranitidine also has the advantage of an unparalleled safety record. For more than 14 years, doctors have prescribed it to provide effective relief from dyspepsia. Ranitidine's lack of clinically significant drug interactions[4] and no increase in frequency of adverse events at up to 16 times the OTC dose versus placebo[5], underline the fact that Zantac 75 is an appropriate recommendation for many of your customers.

Moreover, Medicines Control Agency approval of an amendment to the Patient Information Leaflet, advising patients to now seek advice from their pharmacist as well as their GP, enables

customer improved value for money, there is a profit opportunity for pharmacy staff who offer existing Zantac 75 users the best value for money pack over the Christmas period.

Further information is available from Warner-Lambert Consumer Healthcare, Chestnut Avenue, Eastleigh, Hampshire SO53 3ZQ.

Legal status P.

References

1 Audience Selection, 1995.
2 Chemist & Druggist, 1993, December 4: 1017-22.
3 Taylor Nelson AGB.
4 Klotz U et al. The drug interaction potential of ranitidine: an update. Pharmacol Ther 1991; 50:233-44.
5 Mills J G et al. The safety of ranitidine in over a decade of use. Aliment Pharmacol Ther 1997; 11:129-137.
6 AC Nielsen.

SCRIPTspecials

Jevity Plus fills a gap

Jevity Plus is a new fibre feed supplying 1.2Kcal/ml which meets 100 per cent of the recommended nutritional intake for vitamins and minerals in 1,000mls and contains fructo-oligosaccharides (10g/1,000mls). It is available in 1 litre (x 8, basic NHS price, £62) and 1.5 litre (x 6, £69.78) ready-to-hang containers supplying 1,200Kcals and 1,800 Kcals respectively. Jevity Plus is ACBS approved and available on form FP10.
Ross Products Division of Abbott Laboratories. Tel: 01628 773355.

Andropatch 5mg

Smithkline Beecham is extending its Andropatch range with a new higher strength which delivers 5mg testosterone transdermally every 24 hours (pack of 30, basic NHS price of £48).
Smithkline Beecham Pharmaceuticals. Tel: 01707 325111.

Barkat Breads

Gluten Free Foods is introducing Barkat Gluten Free – Wheat Free Rice Sliced Bread in white and brown variants. The products are also corn, dairy and soya-free with no cholesterol and a shelf life of 12 months. Both products are ACBS approved for prescription use. The basic NHS price of a 450g loaf is £2.79 and the retail price is £3.49.
Gluten Free Foods. Tel: 0181 952 0052.

Mexitil Perlongets

From January the pack size of Mexitil Perlongets will change from 56 to 60 capsules. The new basic NHS price will be £12.71.
Boehringer Ingelheim. Tel: 01344 424600.

P&U makes alterations

Kelfizine W has new markings and is now marked with 'LONGUM'. In addition, P&U has changed the name of Flexotard 100mg to Flexotard MR and all future supplies will carry the name Flexotard MR 100mg.
Pharmacia & Upjohn. Tel: 01908 661101.

Colour change

CP Pharmaceuticals has changed the colour of its erythromycin 250mg tablets from red to white/off white.
CP Pharmaceuticals. Tel: 01978 661261.

Innohep indications

Innohep vials and syringes (20,000 IU) are now licensed for the treatment of pulmonary embolism.
Leo Pharmaceuticals. Tel: 01844 347333.

Preservex packaging

Preservex (aclofenac) has a new pack featuring the UCB Pharma logo. The company acquired the rights for Preservex earlier this year from Bristol Myers Squibb.
UCB Pharma. Tel: 01923 211811.

Tonocard 400mg

Astra is discontinuing Tonocard (tocainamide) tablets 400mg with immediate effect. Named patient supplies remain available from Marian Smith on 01923 272405.
Astra Pharmaceuticals Ltd. Tel: 01923 266191.

Asacol packs change size

Smithkline Beecham has made changes to the packs of Asacol Suppositories 250mg and 500mg and Asacol Foam Enema. In addition to regulatory changes the company has used colour coding to differentiate clearly between products and strengths.
Smithkline Beecham Pharmaceuticals. Tel: 01707 325111.

Nardil storage needs change

The storage conditions for Nardil (phenelzine) tablets have been changed following the identification by Parke Davis of stability problems at room temperature.

When stored at room temperature the potency of the tablets slowly decreases over their normal shelf-life. Therefore, Nardil tablets should now be stored in a fridge at between 2-8 deg C.

Tablets may be stored at normal temperatures (below 25 deg C) for short periods, for example when the patient is travelling or at work.

The Data Sheet for Nardil has been updated and new packs are now labelled with the new storage conditions.

Patients should be advised that once they have used up their existing supply any subsequent supplies of the drug should be kept in the fridge.

Parke Davis says it is not necessary for pharmacists to return any old stock as the decrease in potency has not been shown to affect the safety and efficacy of the product.

Parke Davis Research Laboratories. Tel: 01703 620500.

Terfenadine warnings

The Committee on Safety of Medicines has issued new advice on drugs which should not be prescribed with terfenadine because of the risk of cardiac arrhythmia's.

They are: nibefradil (Posicor); serotonin re-uptake inhibitors (fluovoxamine, nefazodone, sertraline); HIV protease inhibitors (indinavir, ritonavir, saquinavir); and kisapride. All these drugs reduce the hepatic metabolism of terfenadine, allowing it to accumulate in the body.

Avian flu advice

The NHSE's Flu Advisory Committee is re-assuring GPs and pharmacists after media reports about a new strain of avian flu in Hong Kong. The key public health messages are:

- there is no evidence of person to person spread at present
- cases in Hong Kong are being vigorously investigated
- no extra precautions are recommended for visitors
- anyone returning from hong Kong with flu-like symptom should seek medical advice.

MEDICAL MATTERS

Diabetes cases set to double by 2010

By 2010 the people in the UK with diabetes is likely to increase by more than 1.5 million, according to a report in *Diabetic Medicine*.

Globally, the number of patients with diabetes is expected to double by this date, from 123 million in 1995 to 220 million. Most of the new cases will be of the non-insulin dependent type, which normally present in late middle age.

Contributing factors to this increase include less physical exercise, poor diet, obesity, and and a growing elderly population. Developing countries in Asia and Africa will see some of the largest increases, with Asia predicted to be home to almost two thirds of the world's diabetics.

One positive outcome is that the number of diabetics requiring insulin to control their disease continues to fall and is expected to drop to 180,000 by 2010.

When your customers need powerful pain relief, there's no better recommendation than Nurofen Plus. It is the potent combination of ibuprofen and codeine in Nurofen Plus which ensures that it is an ideal treatment for migraine, tension headache, cramping period pain, dental pain, neuralgia, sciatica, lumbago and rheumatic pain. When extra relief is called for, recommend nothing less than Nurofen Plus. With dual action pain relief and proven tolerability, it's clear why Nurofen Plus is the fastest growing analgesic in pharmacy.

NUROFEN PLUS 24 Tablets
ADVANCED DUAL ACTION FOR POWERFUL PAIN RELIEF

ibuprofen codeine

RECOMMEND NOTHING LESS

A week in the life of.....

... Julia Bate BSc, MRPharmS, a pharmacist from St Helens in Merseyside, shares her experience of her first week working within the 'Extended Role'

Julia Bate: probably a typical week for most community pharmacists...

At last the day arrived when, for the first time, I would be seeing real patients as part of the new cardiovascular project developed by the local health authority.

After what felt like months of letters and training sessions, as well as a sea of paperwork which almost fill the dining room, I have been into my two GP practices to read the notes of those angina patients who have been selected to take part in the project.

The time allocated for seeing each patient is half an hour, during which time they are asked to complete a questionnaire on the severity of their angina. I have to complete various forms regarding their level of activity – body mass index, diet, medication, cholesterol levels, blood pressure etc – and review them for any changes over a six month period.

> The worst question I have to ask is "Do you have any other medical conditions?"

The worst question that I have to ask is: "Do you have any other medical conditions?" One elderly gentleman subjected me to a verbal tour of his entire anatomy. He had in his possession a diary which he had kept for the past 13 years, apparently with half a page dedicated to the state of his health for each day! My name was duly entered on the appropriate page, although what else he wrote about me I will probably never know.

I have to see the patients four times over a six month period, to try to assess whether I have made any impact on, for example, their lifestyle. However, I was told by one man that I needn't think he was coming again, as his trip to see me was a total waste of time. And this was before he had even sat down and heard anything I had to say!

Wednesday saw me working at the local superstore as the locum for the day. I was due to start at 8am, so was up early and eating breakfast by 6.30am.

On my arrival, I was informed of my break times. What a luxury! Having been the owner of an independent, I had not been in the habit of taking a break all day (a point some readers can probably identify with).

There is always a sting in the tail, however, and in this store it was that it was not permissible even to drink coffee within the confines of the pharmacy, so caffeine fixes were only to be had at infrequent intervals.

> I used to think the TGIF brigade were a bunch of wimps, but this time I really did think, "Thank goodness it's Friday"!

A patient whose daily aspirin formulation had been amended by his GP from enteric-coated to dispersible formulation accused me of trying to poison him when I dispensed the prescription as written.

He then threatened to sue me, and became even less impressed with me when he ascertained that I wasn't on first name terms with the consultant who had initiated the enteric-coated treatment.

No amount of explaining was going to convince him that enteric coating didn't prevent the possibility of the aspirin causing gastro-intestinal irritation!

Lunchtime brought another hurdle. Meals can be purchased from the staff canteen using the 'credit card' generously provided by the management. Cash is not acceptable. Regrettably, an embarrassing situation developed when I came to pay for my sandwich, only to find that there was just 5p credit remaining on the card.

Fortunately, the situation could be remedied by adding credits to the card by placing money in a machine located at the other end of the store. Eventually I managed to obtain the now longed-for sandwich with just enough time to eat it before having to return to the shop floor.

Although I passed an enjoyable day, with very helpful and pleasant assistants, I was not too sorry to go home at 7pm and leave the next locum to cope until midnight. I wonder if it is really financially viable for the pharmacy to remain open until midnight and the rest of the store for 24 hours a day.

On returning to one of the surgeries on Thursday, I was informed by the doctors that, although the agreed protocol was that a copy of my forms was to be left in the folder with the patients' notes, the forms were, in fact, too bulky.

They would, therefore, like me to remove them all and place them in a separate file and, as a result, Friday morning found me back in the surgery, filing forms.

Later, I passed an uneventful but enjoyable afternoon at the second surgery. I have to admit that when I used to work on Saturdays, I used to think that the TGIF brigade were wimps, but this time I really did think, "Thank goodness it's Friday"!

PHARMACY update

COPD takes its toll

In 1994, 25,977 patients in England and Wales died from chronic obstructive pulmonary disease (COPD) compared to 1,516 from asthma. Yet COPD has a lower public profile than asthma. GP Dr David Price asks why

All COPD conditions involve chronic obstruction of respiratory flow

When asked to picture a patient presenting with a 'crippling disease of the airways', most people think of an asthmatic, possibly a child, in the throes of an acute exacerbation, desperately searching for their metered-dose inhaler and relief.

Compare this with the COPD patient, over 50 years old with breathlessness, wheeze and productive cough, whose disease is probably self-inflicted by smoking and who responds relatively poorly to treatment.

No wonder there is such a gulf between these two images in the public perception and, until recently, that of healthcare workers.

The good news is that recent research has raised the profile of COPD to the extent that international bodies responsible for respiratory care are now producing guidelines and they, too, are attempting to raise the profile of the disease.

Definition

COPD is not a single entity but a collection of conditions that share the features of chronic obstruction of expiratory flow. As a diagnostic label, it encompasses many previously used clinical descriptions including chronic bronchitis, emphysema, chronic obstructive airways disease, chronic airflow obstruction and some cases of chronic asthma which have resulted in irreversible lung destruction.

Mechanisms underlying COPD

COPD is a clinical syndrome derived from a number of different mechanisms with varying proportions in each individual patient:

- **chronic bronchitis** – with increased secretions and airway wall inflammation
- **small or peripheral airways disease** – increased mucus, airway wall thickening, scarring and narrowing
- **emphysema** – permanent destruction of the alveoli, airspaces distal to the terminal bronchiole. On lung expansion, elastic recoil is reduced and pressure to drive expiration is lost. There is also a drop in intraluminal pressure – needed to maintain airway patency during forced exhalation.

The key features of COPD are of a slowly progressive condition characterised by marked airways obstruction which does not change markedly over time. Under the microscope, pathological changes can be seen in the large airways, small bronchi and bronchioles, and in the lung tissue itself as well as lung blood flow.

Hypersecretion of mucus and airway inflammation occurs primarily in the large airways. The small airways are the sites of increased airways resistance. The alveoli are also destroyed and this is described as emphysema.

Presentation

Most COPD patients have smoked for at least 20 years and commonly present in the fifth decade with a productive cough or an acute respiratory complaint.

By the sixth or seventh decade, exertional dyspnoea is usually a feature and intervals between acute exacerbations become shorter as the disease progresses. In its earlier stages, slow, laboured expiration, plus wheezing on forced expiration may be apparent. A worsening in airflow obstruction is associated with

Continued on PII ▶

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1076), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTION BEING PUBLISHED IN *C&D* JANUARY 10, PROVIDES ONE HOUR'S CONTINUOUS EDUCATION

OBJECTIVES

- To be familiar with the incidence and definition of COPD
- To be understand the clinical syndrome underlying COPD
- To recognise the differences between COPD and asthma
- To appreciate the problems in diagnosing COPD
- To be familiar with new guidance on treating COPD
- To appreciate the pharmacist's role in promoting lifestyle changes

◀ Continued from PI

hyperventilation and a gradual increase in the anteroposterior diameter of the chest.

Causes

The underlying causes of COPD have still to be fully elucidated. Those thought to be relevant are listed below (see Table 1), but cigarette smoking is felt to be generally the most important.

Disease classification

Most recent guidelines helpfully classify COPD into severity of disease rather than presumed underlying causes. The objective measure used for this and monitoring progression of the disease is Forced Expiratory Volume in one second (FEV 1).

Measurements are taken with a spirometer and compared to well-defined normal ranges that take into consideration age, height, sex and race. Results are often expressed as a percentage of the predicted normal.

Under-diagnosis

Unfortunately, much COPD is not diagnosed or diagnosed too late. It has been estimated that only about 25 per cent of cases are being diagnosed. There are a number of reasons for this:

- early COPD is difficult to diagnose because of the lack of symptoms in the early stages. Currently, routine annual spirometry is the best method to detect early disease, but because of the major resource requirement, it is routinely only provided for those at high risk, eg those with proven risk factors such as those with alpha 1-antitrypsin deficiency
- patients may present late – often regarding it as normal to cough and be short of breath because they smoke
- doctors may miss the diagnosis – especially in the milder patients who usually turn up for emergency consultations with 'bronchitis'
- confusion between COPD and asthma may lead to misdiagnosis. This is because of similarities between COPD and asthma and because the two syndromes may overlap (see Table 3), with some COPD patients also suffering from asthma and a proportion of chronic asthma sufferers going on to develop COPD. This is unfortunate, because while there are similarities in treatment, it may mean that patients with COPD receive inappropriate treatment, eg too much inhaled steroid and too little anti-cholinergic therapy.

Poor diagnosis is a major problem because if COPD is caught early and patients were to stop smoking, much of the disease progression would be arrested (see Fig 1).

Recent interest

Recognition of the significant morbidity associated with COPD, greater understanding of the disease process, advent of new effective treatments, together with a gradual appreciation of the degree of misdiagnosis, have served to focus attention on clearly defining and characterising COPD.

Clear definitions are a fundamental step in developing management guidelines, and the first national guidelines were issued by the British Thoracic Society this month (see piv).

Interest has also been promoted by a recent change in emphasis in the way in which the efficacy of available treatments is assessed.

Reduced useful lung volumes and slow forced emptying of the lungs are characteristics of COPD, hence the current policy of assessing patients' lung function by measuring FEV1. However, many researchers feel such measurements of lung function may not be the best means of assessing prospective management strategies.

What is now felt to be clinically relevant is improvement in the patient's quality of life. Quality of life measurements have previously been ignored, due to their poor correlation with FEV 1. However, they are now incorporated into the new COPD management guidelines for this very reason, and are part of most new studies into COPD.

The shift in the 'burden of financial responsibility' from secondary to primary NHS care must also have helped sharpen doctors' and pharmacists' interest in tackling COPD. Limited resources must be effectively targeted and COPD eats up a lot of NHS resources, particularly in hospital costs.

Treatment options

It is very easy, when thinking about an illness, to consider medical intervention but COPD is above all a disease helped most by major lifestyle intervention.

The biggest of these, and also the most difficult, is to stop smoking (*see overleaf*). Smoking cessation is not the only lifestyle change worthy of consideration. Dietary advice is also important:

- if a patient is overweight, a sensible weight reducing diet should be advised
- if, however, in late stage COPD, because of massive hyperventilation the patient has become grossly underweight, then dietary supplementation may need to be considered.

Other life-style advice shown to be worthwhile is to maintain fitness as much as possible. Significant improvements have been achieved by the use of active rehabilitation programmes.

Management guidelines recommended tailoring treatment to the severity of

Continued on PIV ▶

Figure 1

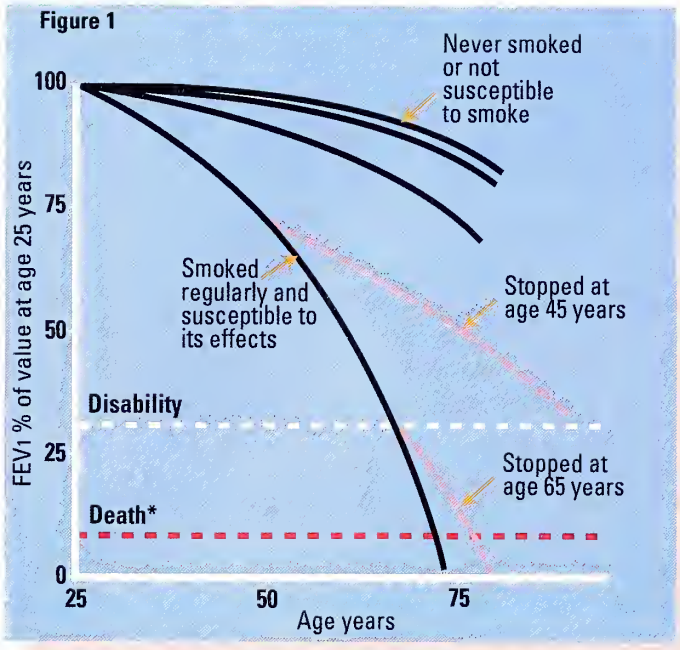


Table 1: Underlying causes of COPD

Degree of certainty	Environmental factors	Host factors
Established	Cigarette smoking	Alpha 1-antitrypsin deficiency
	Some occupational exposures, eg cadmium and silica	
Pretty certain	Air pollution	Low birth weight
	Poverty	Childhood respiratory infection
	Alcohol	Atopy
		Family history
Possible	Adenovirus infection	Blood group A
	Vitamin C deficiency	Genetic predisposition
		IgA non-secretor

Table 2: Classification of COPD

Severity	*FEV1 (per cent predicted)*	*Clinical picture*
Mild	60-80 per cent	Smokers cough; little to find clinically; little or no breathlessness
Moderate	40-59 per cent	Short of breath on moderate exertion; cough; variable abnormal physical signs, eg wheezes
Severe	< 40 per cent	Breathless on minimal exertion; wheeze and cough prominent; over-expanded lungs; cyanosis; peripheral oedema

Table 3: The differences between COPD and asthma

	COPD	Asthma
Age of onset	Typically fifth decade	Any age
Smoking	Usually current, ex-smoker	May or may not smoke
Cough	Morning, usually productive of sputum	Usually at night
Wheeze and breathlessness	Gradual onset, often persistent and progressively worse	Often episodic May be persistent

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Reference
1 IMS Medical Data Index Q2 1995

Date of preparation December 1995
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Table 4: Aims of treatment:
- to minimise progression of the disease
- to reduce symptoms
- to reduce exacerbations
- to improve exercise tolerance
- to increase quality of life

Table 5: Management and treatment of COPD

Mild disease	*Moderate disease*	*Severe disease*
STOP SMOKING	STOP SMOKING	STOP SMOKING
Encourage exercise	Encourage exercise	Encourage exercise
Dietary advice	Dietary advice	Dietary advice
PRN inhaled beta-agonists or anticholinergics	Regular inhaled beta-agonists and/or anticholinergics	Regular inhaled beta-agonists and/or anticholinergics
	Inhaled steroids if proven benefit – from steroid trial	Inhaled steroids if proven benefit – from steroid trial
	Consider long-acting beta-agonists	Consider long-acting beta-agonists
		Consider regular nebulised beta-agonists and/or anticholinergics
		Consider long-term oxygen (16 hours/day)

◀ *Continued from PII*

the disease. The most recent advance is the finding that the long-acting beta-agonist salmeterol xinafoate can significantly improve quality of life in those with moderate to severe COPD and that it may remove much of the need for short acting bronchodilators.

Role of the pharmacist

The pharmacist already has a fundamental role in the on-going management and support of patients with COPD. It has been well documented that patients with chronic long standing diseases, or their carers, see their pharmacist more often than their GP whether it be to simply collect a prescription or to seek advice.

There are a number of key areas where the pharmacist can advance the care of patients with COPD:

- helping with diagnosis – pharmacists can significantly improve the level of COPD diagnosis through positive intervention They are ideally placed to spot customers with mild to moderate COPD whose breathing is laboured and who constantly purchase OTC cough medicines.

Similarly, the alert dispenser will recognise the long-term diagnosed asthmatic collecting repeat prescriptions, but constantly complaining that the treatment has little beneficial effect

- giving advice – this can be on any aspect of the disease or its treatment, in particular, explaining what the diagnosis may mean to the patient and how prescribed treatments should be taken
- stopping smoking – treatments available to help with this are not available on FP10. The pharmacist is often the first port of call for those wishing to stop smoking and has a key role in providing advice as well as providing replacement therapy
- checking inhaler technique – while many patients will have this checked by their GP or practice nurse, this may have been rushed or omitted due to lack of time. It has also been shown that patients forget what they were taught over a period of time
- spotting non-compliance – many patients, estimated at approximately 60 per cent, do not comply fully with their planned treatment regime.

The commonest problem is patients failing to take or even collect prescriptions for preventative drugs such as their inhaled steroids. The pharmacist is ideally placed to spot such non-compliance and address it with the patient and possibly the GP

- spotting worsening of patients' COPD – if patients with known COPD present requesting cough mixtures etc, it is worth finding out what they are supposed to do in these circumstances.

If they have no treatment plan it might be advisable for them to see their GP or practice nurse

- spotting treatment failure or gradual deterioration – if patients complain of this it is worth checking for non-compliance or poor inhaler technique. If these seem to be in order then treatment review may be justified
- spotting depression – if the patient is or appears to be depressed, then it is important that this is addressed because it obviously worsens the quality of life dramatically
- an oxygen service for those receiving long-term oxygen therapy.

As our understanding of COPD changes, there are opportunities for collaboration between those caring for patients with the disease. It might, for instance, mean that the pharmacist is involved more formally in diagnosis, inhaler device selection and technique teaching and long-term monitoring of lung function.

British Thoracic Society's new guidelines on COPD

The British Thoracic Society has published the first guidelines on the management of chronic obstructive pulmonary disease.

It recommends early diagnosis, extra efforts to help patients give up smoking and an escalator approach to treatment.

Other recommendations are:

- patients with suspected COPD should be offered spirometric testing by their GP, which gives a more accurate indication of lung function than a series of peak flow measurements
- smoking cessation is essential at all stages of the disease because although it cannot restore lung function it can prevent the accelerated decline seen in many patients
- beta-agonist or anti-cholinergic bronchodilators are recommended for mild COPD where lung function (measured by forced expiratory volume) is 60-80 per cent of the predicted normal. For moderate or severe disease, a combination of bronchodilators may be helpful
- all patients should be considered for a steroid reversibility trial – only those who are positive should have inhaled steroids. Home nebulisers should only be prescribed for regular use after formal assessment.

If you require more information, the 'Guidelines for the Management of Chronic Obstructive Pulmonary Disease' are published in the latest issue of *Thorax* 1997; **52 (suppl 5)**:S1-32.

Stopping smoking

No-one will stop smoking unless they really want to
People generally do not like being told what to do

A model of behavioural change suggests patients are in three positions when it comes to major lifestyle change:

- Ready to change – all they need is the slightest encouragement
- Considering change – if this group are encouraged – classically by asking them to tell you about the positives and the negatives of a particular course of action and then what they feel they should do – they will make their own decision
- Unready to change – this group will not respond at this stage but it may be possible to move them to the group considering change – written material is particularly helpful here.

If patients decide they want to stop smoking then the pharmacist can be particularly helpful in providing support and help with nicotine replacement therapy.

Summary

With significant advances in the management of COPD, it can no longer be an ignored illness. Rather there must be some optimism that the progression of the disease can be arrested and the quality of life of sufferers improved. The pharmacist is already a key person in the team caring for these patients and should become even more so.

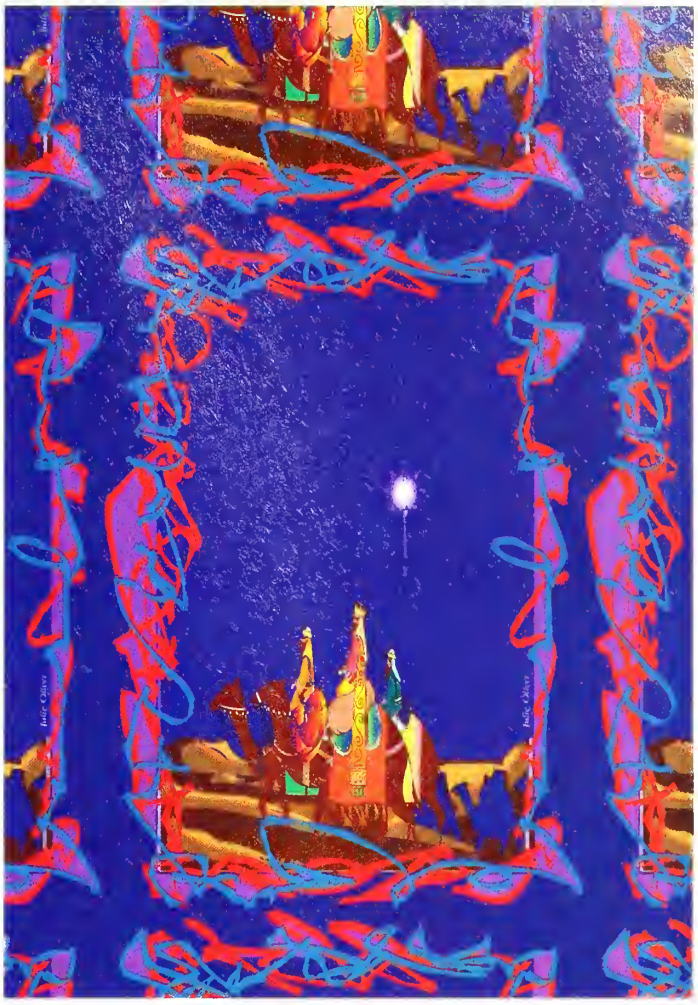
C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning material until March 2000.*

ACTION PLAN

1. Make sure you can use a peak flow meter and advise on its use. Check that you understand the predicted value for males and females at different ages.
2. In your practice workbook, note the symptoms you observe for COPD and record differences seen for asthmatic patients.
3. Talk to GPs to find out who runs asthma and/or COPD clinics.
4. Think about ways to educate the local community to recognise COPD and asthma. You could give talks to local groups.
5. Develop your own smoking cessation aid pack, thinking about both pharmacological and psychological aspects.

Of mice and magi

Gold, frankincense and myrrh. Just pause a moment and think of those Magi, bringing valuable gifts, suggests Christine Horden



Astronomers, were they? Learned wise men? Kings or leaders of their tribes? Whatever or whoever they were, they knew enough of prophecy to be convinced by portents in the sky, and journeyed many miles to recognise the long-awaited Messiah.

An extra bright star? The juxtaposition of Saturn and Jupiter – rare, but certainly chronicled. Whatever, after a long dry summer they set off, their journey taking them towards Bethlehem by December, passing through the fields where shepherds would have been watching their flocks by night.

But what were they to take with them, to pay homage? They couldn't arrive empty-handed, but there were no Argos stores or branches of Mothercare on the ancient caravan routes to Judea.

They turned to natural products – to earthly gifts. The earth was a rich and virtually untapped source of treasures: pearls of the ocean, gems from the mountains or gold from the mines.

The three gifts

Gold, their first gift, was the symbol of kingship. Today it is possessed by the rich, striven for by the ambitious and coveted by the criminal. A precious metal, it is prized, displayed, rushed for, panned for, enjoyed or, more likely, securely stored in bank vaults.

The second gift was frankincense, and in religious terms, this was symbolic of priesthood. Like gold, it is a natural product, being an oleo-resin seeping from the bark of the trees of the *Boswellia* genus.

Frankincense appears as small tears up to 3cm long. These are brittle and break easily in the fingers. They are usually pale yellow, frequently with a greenish or bluish tinge. The tears have a distinguished balsamic perfume, and this becomes stronger when broken tears are rubbed in the hand as the aromatic oils are vaporised by hand warmth. The tears have an aromatic and slightly bitter taste, and soften to a plastic mass when chewed.

The tears are collected, sorted and transported for export. Frankincense's chief use is in the manufacture of incense for burning in religious ceremonies.

Although it has no medicinal value, frankincense is used in the perfume and cosmetics trade. Today, charred frankincense is still an ingredient of kohl, the dark eye-shadow, originally used by the Egyptians.

The third gift of the Magi was myrrh. An onomatopoeic word, suggestive of gathering gloom, myrrh has a character of its own, even though its origins are somewhat similar to frankincense.

Myrrh is also an oleo-resin, exuding from the bark of the *Commiphora molmol*, genus *Burseracea*. This is a bush rather than a tree, growing mainly in the forests of Arabia and around Somalia. It is sturdy with knotted branches.

There are ducts within the bark, and the tissue between them breaks down to form large cavities. These fill with granular secretion which is freely discharged when the bark is hurt in any way. Damage can be deliberate by humans harvesting the product, or accidental, by animals. On the plains of Africa, an elephant will quickly trample or uproot *Commiphora* or acacia bushes, which are not to their liking, in their hunt for their favourite foods.

The resin first seeps from the bark as a yellow-white fluid, but quickly hardens to a firm red-brown mass. The commercial drug is exported in this form.

Myrrh appears in regular rounded masses varying in size from small grains to fist-size lumps, but the average is the size of a walnut. These masses break fairly easily. They have an agreeable aromatic perfume, but a bitter acrid taste.

Several species of myrrh are recognised in commerce, and much of it is imported from the East Indies in chests weighing 1 or 2 cwt. It is best purchased in mass, because adulteration by small stones or vegetable matter can be detected easily.

In ancient times, long before the days of Arden or Armani, the most prized variety came from the Troglodytes. Whether it really was superior is not confirmed – perhaps they were just better salesmen!

It seems probable now that the best drug comes from Somalia, is bought at the fairs of Berbera by the Banyans of India, and is shipped to Bombay for sorting and export.

Myrrh has been used from remote ages as an ingredient in incense, perfumes etc, in the holy oil of the Jews and Kyphi of the Egyptians for embalming.

The religious connotations surrounding myrrh connect it with the Passion, requiems and services of mourning.

Medical uses

There are several pharmaceutical uses and its tincture is prepared by macerating one part myrrh in five parts of 90 per cent alcohol. This is used as a healing agent and an astringent, a tonic (in drops), a carminative, and a healer for mouth ulcers and sore gums.

When ground down with camphor and balsam of Peru, it has been used as an effective rubefacient.

It is now being investigated for its pain-relieving properties, following experiments held at the University of Florence.

In this investigation, a suspension of ground commercial myrrh was administered to a group of mice. The mice were then placed on a metal plate heated to 52°C, The scientists then timed how long it took before the mice licked their paws. Apparently, the mice given myrrh lasted 20 minutes without licking, compared with 14 minutes for mice without myrrh.

From this scenario, myrrh was found to contain two sesquiterpenes having analgesic effects on the brain similar to the actions of morphine. Development has not yet been commercially taken up, however.

But perhaps this was why '*vinum muratum*' – wine mixed with myrrh – was offered to Christ shortly before his crucifixion.

If only the Magi had known of these properties, they might have been able to help those poor shepherds, watching their flocks by night, while rubbing their aching chilblains!

New studies suggest that vitamin C can lower blood pressure and may be useful in preventing gastric cancer. The results were presented at a conference sponsored by Merck in Monte Carlo recently

Where next with vitamin C?

Several studies have suggested that vitamin C is important in controlling blood pressure and elevated serum lipids. But the evidence is inconsistent, and Professor Gladys Block, director of the public health nutrition program at the University of California, believes that poorly designed trials could be responsible for these conflicting results.

In some studies, subjects are asked to record their fruit and vegetable consumption, but not foods such as cereals and soft drinks which are often fortified with vitamin C.

Foods naturally rich in vitamin C also contain other anti-oxidants and it is difficult to know whether health benefits are due to the vitamin C or these other compounds. In addition, she said, many trials do not assess alcohol intake or lifestyle factors that might affect blood pressure.

With researchers at the National Cancer Institute, Professor Block has carried out a strictly controlled study which took account of all these factors.

Sixty-eight healthy, non-hypertensive men who had been taking 60mg of vitamin C daily, took just 9mg every day for four weeks followed by 117mg a day for four weeks. They then repeated the two-month depletion-repletion cycle.

During this time, vitamin C was the only variable in the diet. Alcohol intake and smoking were controlled and account was taken of physical activity, body weight and other factors that might have influenced blood pressure.

Professor Block found that, at all ages, high plasma ascorbate levels were associated with significantly reduced blood pressure and high HDL cholesterol. Reduced ascorbate was linked with higher blood pressures and low HDL cholesterol. This pattern was consistent over the periods of repletion and depletion.

"This small study gives convincing evidence that there is a link between vitamin C and cardiovascular risk factors," she said.

Professor Balz Frei, a biochemist and director of the Linus Pauling Institute, Oregon State University, explained that there are several mechanisms by which vitamin C could help in coronary artery disease.

As an anti-oxidant it protects against lipid peroxidation induced by free radicals, which leads to atherosclerosis. There might also be other, non anti-oxidant, mechanisms such as an action on cholesterol metabolism.

There is increasing interest in the effects of vitamin C on nitric oxide, which is produced in the lining of healthy blood vessels and is inactivated by free radicals. Nitric oxide inhibits platelet aggregation and promotes smooth muscle relaxation. In patients with coronary artery disease, acute doses of 2g vitamin C dramatically improved vasodilation within two hours; 500mg daily for 30 days has a similar effect.

Vitamin C seems to increase nitric oxide concentrations and this may account for its anti-hypertensive action, he suggests.

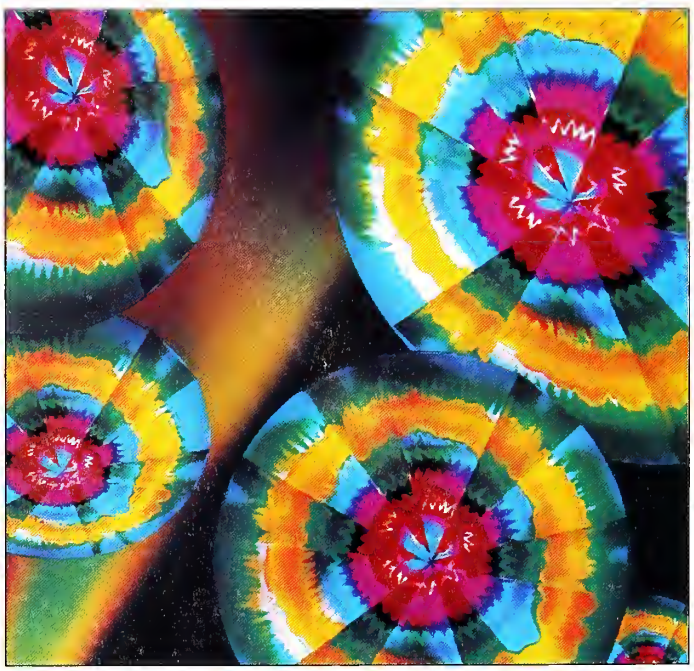
Gastric cancer

Vitamin C might protect against gastric cancer, according to Professor Christopher Schorah, University of Leeds.

The vitamin seems to prevent formation of two types of potential carcinogens in the stomach – nitroso compounds derived from food constituents, and reactive oxygen species (a type of free radical) which are produced by the body in response to infection.

Further support for vitamin C's protective role comes from the recent discovery that it exists in high concentration in the stomach mucosa. In healthy stomachs, it is secreted into the gastric juice at levels higher than those found in the plasma. But infection with *Helicobacter pylori*, a known carcinogen, reduces the stomach's ability to concentrate vitamin C.

His research has shown that vitamin C concentrations in the stomach increase after *H. pylori* eradication. Giving supplements after eradication further increased vitamin C levels, but they had no effect if *H. pylori* was still present. Eradicating the bacteria also reduces inflammation and brings about other changes which lessen the risk of cancer.



Vitamin C crystals under the microscope

Professor Schorah explained that gastric cancer develops slowly over several years, with vitamin C levels in the stomach decreasing as the process continues.

Although there is evidence that increased consumption of fruit and vegetables protects against the disease, the only randomised clinical trial of vitamin C therapy showed no benefit.

Because the cancer grows so slowly, trials are difficult to carry out, he said, so there is a need to identify early changes to the DNA in stomach cells which could be used as markers for testing the effects of vitamin C.

How much to take?

Several speakers thought there was a need to increase the recommended daily amount of vitamin C from the current levels of 40-60mg.

They suggested that 150-200mg daily was more appropriate for preventing disease in healthy people, while higher doses might be useful in treating degenerative diseases.

Dr Mark Levine, from the National Institute of Health, Bethesda, has studied steady state vitamin concentrations in plasma and tissues at various doses, together with bioavailability and excretion rates.

He concludes that the RDA should be increased to 200mg, which is enough to saturate the tissues. Doses over 1g daily increased oxalate and urate excretion so carried a risk of kidney stones in susceptible people.

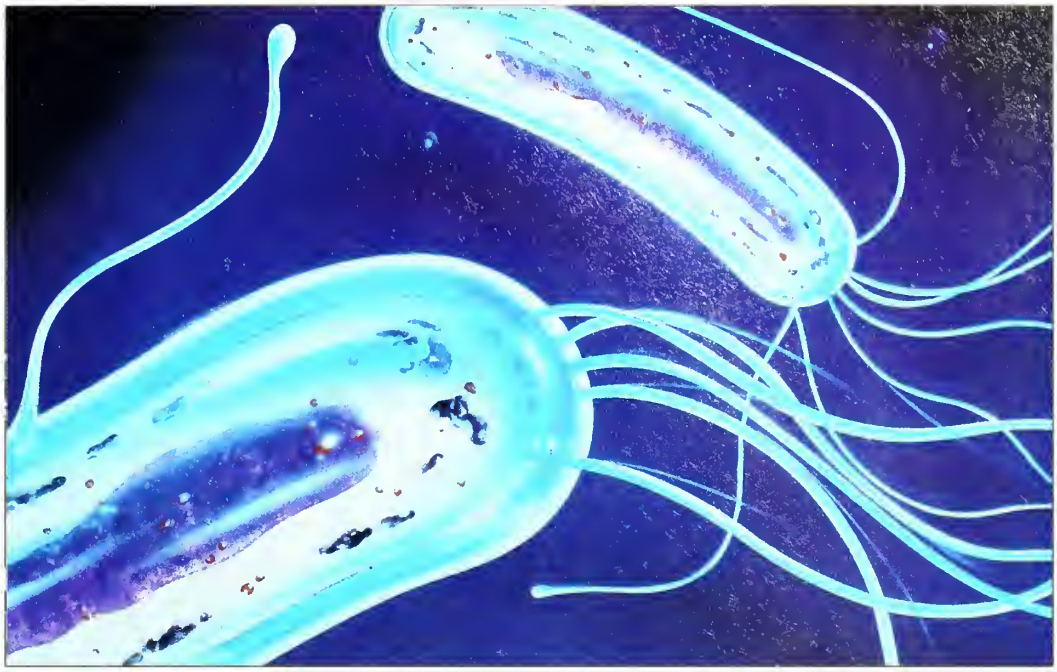
But Professor Anthony Diplock of the International Anti-oxidant Research Centre, United Medical Schools of Guy's and St Thomas's Hospitals, London, thought vitamin C was unlikely to cause kidney stones or increase urate formation in people with gout.

An extensive review of the world scientific literature showed that vitamin C had a good safety record. In cases where detrimental effects had been suggested, further investigation had proved them to be unfounded.

Professor Diplock said there was a need to consider carefully reports that, in certain circumstances, high intakes of ascorbic acid might have a pro-oxidant rather than an anti-oxidant effect, resulting in damage to DNA bases, although preliminary work at his centre suggested that vitamin C might have an effect on DNA repair.

H. pylori: towards a consensus

Experts have been trying to agree on the best approach to *H. pylori* eradication. Adrienne de Mont looks at current thinking



Wyeth Laboratories

Research is in progress on vaccines to prevent and treat *H. pylori* – another possible approach for the future

Helicobacter pylori eradication is becoming increasingly accepted as a cost-effective way to treat peptic ulcer disease and as a possible means to prevent gastric cancer. But there has been much debate over the best approach to eradication.

In September 1996 a group of experts got together in Maastricht with the aim of reaching a consensus. This meeting of the European Helicobacter Pylori Study Group (EHPSG) resulted in guidelines being published earlier this year.

The group accepted that the patient's symptoms and age are important in deciding whether treatment should be in the hands of a GP or a specialist. GPs can use non-invasive methods of detecting *H. pylori* which save patients the discomfort of endoscopy and reduce hospital costs.

Most of the experts agree that patients under 45 with dyspepsia but no 'alarm symptoms' such as anaemia, weight loss and difficulty with swallowing, and who test positive for *H. pylori* for the first time, could be treated by a GP. It is important, however, to rule out malignancy risk factors such as family history of gastric cancer.

For patients over 45 and those with alarm symptoms, irrespective of age, EHPSG decided that the best course of action is referral to a specialist for endoscopy. It is also better for patients with a known history of gastric ulcer to undergo endoscopy with biopsy until the ulcer is healed, in case there is malignancy.

Another patient group which warrants referral is that where eradication therapy has failed; patients might need further biopsies to test for antibiotic sensitivities and possible resistance

When to use

The group decided that *H. pylori* eradication therapy should be strongly recommended in all infected patients with:

- peptic ulcer disease, including bleeding ulcers
- low grade gastric MALT (mucosa associated lymphoid tissue) lymphoma
- advanced and progressively worsening gastritis
- following resection of early gastric cancer or pre-cancerous lesions.

Eradication is advisable in:

- functional dyspepsia after full investigation
- family history of gastric cancer
- long-term proton pump inhibitor treatment of gastro-oesophageal reflux disease, as this may accelerate progression of *H. pylori*-induced gastritis
- planned or on-going treatment with nonsteroidal anti-inflammatory drugs, as studies have suggested that *H. pylori* eradication might prevent peptic ulceration following NSAIDs
- in response to the patient's wishes.

Treatment is not currently recommended by EHPSG in the following groups:

- for large scale gastric cancer prevention for people with no known risk factors
- those with no symptoms or relatives of those infected, (although it is advisable to treat those who are infected and have a family history of gastric cancer even if they are asymptomatic).

EHPSG favours triple therapy with a proton pump inhibitor plus two antibiotics from a choice of three: clarithromycin, a nitroimidazole (metronidazole or tinidazole), and amoxycillin. High eradication rates (85-95 per cent) have been achieved.

These regimens are now considered to be more effective, have fewer side effects and offer better patient compliance than earlier bismuth-based triple therapy.

Antibiotic resistance

One potential problem is the development of antibiotic resistance, which is most prevalent with metronidazole, particularly in developing countries. There is a possibility that widespread eradication therapy could lead to resistance developing in other bacteria. Avoiding antibiotic monotherapy and ensuring patient compliance helps to minimise this risk.

Seven days' treatment is recommended with:

- a standard dose proton pump inhibitor twice daily (that is, omeprazole 2 x 20mg, lansoprazole 2 x 30mg or pantoprazole 2 x 40mg), plus
- *either* metronidazole 400mg twice daily or tinidazole 500mg twice daily plus clarithromycin 250mg twice daily;
or amoxycillin 1g twice daily plus clarithromycin 500mg twice daily (advisable when metronidazole resistance is likely);
or amoxycillin 500mg three times daily plus metronidazole 400mg three times daily (when clarithromycin resistance is likely).

Follow-up tests should be carried out at least four weeks after treatment has stopped. Quadruple therapy, consisting of omeprazole plus classical bismuth-based triple therapy, is another option if triple therapy fails.

Research is in progress on vaccines to prevent and treat *H. pylori* – another possible approach for the future.

There are still many unresolved questions about the exact role of *H. pylori* in gastro-intestinal disease.

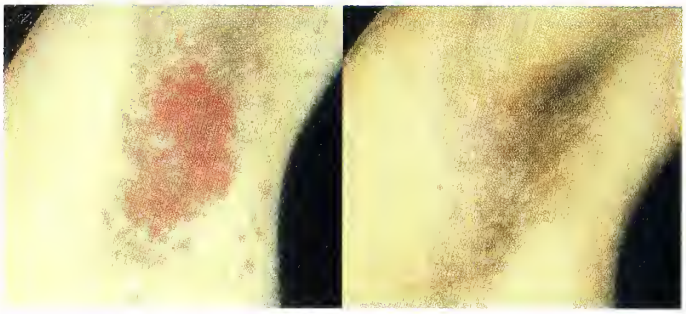
Studies have shown that *H. pylori* populations are highly diverse, with some more likely to cause inflammation than others. Some might even be beneficial, so eradication might not always be appropriate.

Reflux protection

Another theory is that *H. pylori* may protect against gastro-oesophageal reflux disease – patients with this condition are less likely to be infected than are controls.

Duodenal ulcer patients sometimes develop reflux symptoms after *H. pylori* eradication, although this could be a result of a more liberal diet, weight gain and withdrawal of acid suppressing drugs.

High flyers in psoriasis treatment



Psoriasis before treatment Psoriasis after 8 weeks with Dovonex

Psoriasis is a common skin complaint affecting between 1.5-3% of the population.[1] Men and women are both equally likely to suffer from the condition, which can occur at any age.

Psoriasis has a nasty habit of dominating lives. Worrying about the way it looks can knock self-confidence. It may blight careers and restrict socialising. Worse still, over a third of psoriasis sufferers claim that their sex lives are badly affected by having the condition.[2]

Fortunately for those with psoriasis there is Dovonex. Not a steroid, Dovonex is a modern treatment that's clean and pleasant to use. In the UK, Dovonex is the most widely prescribed psoriasis treatment. With over 2 million prescriptions since its launch, Dovonex has now been used for an estimated 12 million patient weeks.[3]

FOR BODY AND FLEXURES

Dovonex is suitable for the long-term treatment of psoriasis and is available as an Ointment and Cream. Studies over 48 weeks show continuous efficacy without increasing side-effects.[4] Dovonex can also be used for treating psoriasis in the flexures.[5]

FOR THE FAMILY

Dovonex can be used for childhood psoriasis too.

THE RANGE

Available as Ointment and Cream, Dovonex comes in a range of 30g, 60g and 120g tubes.

FOR SCALP PSORIASIS

Scalp psoriasis is even more common than psoriasis of the body. Dovonex Scalp Solution is an effective non-steroid option for the treatment of this difficult to conceal site.

HELPING PATIENTS

A selection of patient education handouts are available free of charge from LEO Pharmaceuticals.

Copies of educational materials can be obtained by pharmacists on request from:

LEO Pharmaceuticals,
Longwick Road, Princes Risborough,
Bucks. HP27 9RR.
Tel: 01844 347333

Dovonex®
calcipotriol

You'll like the way they like it

Prescribing information for Dovonex Cream/Dovonex Ointment/Dovonex Scalp Solution. Indications: Cream/Ointment: Treatment of mild to moderate plaque psoriasis (psoriasis vulgaris) affecting up to 40% of skin area. **Scalp Solution:** Topical treatment of scalp psoriasis. **Presentation: Cream/Ointment:** 30g, 60g and 120g tubes. **Scalp Solution:** 60ml bottle. Cream/Scalp Solution contain 50 micrograms calcipotriol per g/ml (as the hydrate). Ointment contains 50 micrograms calcipotriol per g. **Dosage and Administration: Cream/Ointment: Ointment** - apply once or twice daily in adults. For maximum benefit use twice daily. Apply twice daily in children. **Cream** - apply twice daily in adults and children. For Cream and Ointment maximum weekly dose should not exceed 100g in adults, 75g in children over 12 years, 50g in children aged 6 to 12 years. There is limited experience in children under 6 years - maximum safe dose not established. **Scalp Solution:** Apply twice daily. Maximum weekly dose should not exceed 60ml. No experience in children. When Scalp Solution is used together with Cream or Ointment, the total dose of calcipotriol should not exceed 5mg in any week, e.g. 60ml Scalp Solution plus 30g Cream or Ointment, or 30ml Scalp Solution plus 60g Cream or Ointment. **Contra-indications:** Patients with known calcium metabolism disorders. Hypersensitivity to any constituents. **Precautions:** Do not use on the face. Wash hands after application. Avoid inadvertent transfer to other body areas, especially the face. Hypercalcaemia, has been reported in generalised pustular and erythrodermic exfoliative psoriasis. Use no more than recommended dose since hypercalcaemia, which rapidly reverses on cessation of treatment, may occur. **Drug Interactions:** No experience of concomitant therapy with other antipsoriatic products applied to the same area. **Use during Pregnancy:** Animal studies have not shown teratogenic effects but avoid unless no safer alternative. **Side Effects: Cream/Ointment:** Transient local irritation which seldom requires treatment discontinuation. Other local reactions may occur including dermatitis, pruritus, erythema, aggravation of psoriasis, photosensitivity. Facial or perioral dermatitis may occur rarely. **Scalp Solution:** As above, local irritation of the scalp or face may occur, and rarely hypercalcaemia or hypercalciuria. **Basic N.H.S. Price: Dovonex Cream/Ointment:** £8.15/30g, £16.30/60g, £29.40/120g. **Dovonex Scalp Solution:** £22.28/60ml. **Legal Category:** POM. **Product Licence Numbers and Holder: Cream** PL 0043/0188, **Ointment** PL 0043/0177, **Scalp Solution** PL 0043/0190. Leo Laboratories Limited, Princes Risborough, Bucks.
Further information is available on request from
LEO Pharmaceuticals, Longwick Road, Princes Risborough, Bucks. HP27 9RR.

References:
1. Textbook of Dermatology, Oxford:Blackwell.
2. *Int Jnl Derma* 1997;**36**:259-262.
3. IMS Data. Q3 1997.
4. *Jnl Derm Treatment* 1993;**4**:173-177.
5. *Br J Dermatol* 1996;**135**:647-650.

1745 November 1997

A PRIDE IN DERMATOLOGY

PHARMACYupdate: distance learning for pharmacists

Update users – a reminder

Users of the **Pharmacy Update** telephone marking service are advised that they have until February 8 to complete the self-test questions for learning modules carried during 1997. This is to allow delivery of results for the second half of 1997 by the end of February. The final question paper for 1997, covering modules published in December, will be inserted in *Chemist & Druggist*'s January 10 issue.

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to regularly test their understanding and knowledge retention.

C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in *C&D* January 10, which covers this week's CPP-accredited module and those from December 6 issue:

- Anaphylaxis (1074)
- Ear Problems (1075)
- Chronic Obstructive Pulmonary Disease (1076).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

Update Index

The following is a list of modules accredited by the College of Pharmacy practice and published since January 1996

- Communication and the Pharmacist (1001)
- Rheumatoid Arthritis (1002)
- ACE Inhibitors (1003)
- The Endocrine System (1004)
- Sleep Disorders (1005)
- Pituitary Problems (1006)
- Croup (1007)
- Hormonal Contraception (1008)
- Schizophrenia (1009)
- Psoriasis (1010)
- Constipation (1011)
- Methadone (1012)
- Methadone Supervision (1013)
- Beta-blockers (1014)
- Cystitis (1015)
- Palliative Drug Therapy (1016)
- Responding to Symptoms (1017)
- Drug Interactions Part 1 (1018)
- Drug Interactions Part 2 (10 19)
- Malaria (1020)
- Headache (1021)
- Drugs in Sport (1022)
- Indigestion pt1 (1023)
- Sexually Transmitted Disease (1024)
- Cannabis (1025)
- Indigestion pt2 (1026)
- Diuretics (1027)
- Eating Disorders (1028)
- Coughs & Colds pt1 (1029)
- Inhaler Devices (1030)
- Chinese Herbal Medicine (1031)
- Coughs & Colds pt2 (1032)
- Hallucinogens (1033)
- Amphetamines (1034)
- Irritable Bowel Syndrome (1035)
- Acne (1036)
- Lower Back Pain (1037)
- Myalgic Encephalomyelitis (1038)
- Calcium Channel Blockers (1039)
- Stoma Care (1040)
- Dry Skin Problems (1041)
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- Volatile Solvent Abuse (1065)
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- Dysmenorrhoea and cystitis (1068)
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- Pneumococcal infections (1071)
- Eye problems (1072)
- Paediatric medicine (1073)
- Anaphylaxis (1074)
- Ear problems (1075)
- Chronic Obstructive Pulmonary Disease (1076)

The monthly MCQ papers on faxback are for 1997 only:

- January 2039
- February 2042
- March 2045
- April 2048
- May 2051
- June 2055
- July 2059
- August 2062
- September 2065
- October 2068
- November 2071

End of Year Quiz

... or the '*Chemist & Druggist* most devoted reader of the year' competition

With all that spare time on your hands after the seasonal rush, *C&D* thought it would be nice to offer some help. So, in place of a straightforward review of the year, we have set a quiz to stimulate your mind and possibly get you searching through back numbers in the pursuit of knowledge.

We are prepared to offer a prize of £100 for the most complete set of answers sent in by a subscriber, with ten runners-up prizes of 'X-Rayser' clocks.

Send your answers, with your name and address, on a sheet of A4 paper, by January 30, to: Year End Quiz '97, *Chemist & Druggist*, Miller Freeman plc, Sovereign Way, Tonbridge, Kent TN9 1RW

The winner will be the subscriber who sends in the most complete set of correct answers, or, in the event of a tie, the first name drawn out of the hat. Results will be announced in the February 14 issue.

And don't forget, all the answers have appeared somewhere in *C&D* over the past year.

A: Missing words

Complete the *C&D* headlines below using the following words:

a) independence
b) medicine price-cuts
c) Financial problems
d) defray education costs
e) gift scheme
f) fronts
g) rights some wrongs
h) dinner
i) stuffing
j) continuing education
k) brand equalisation
l) Electronic
m) walkabout
n) needed
o) punish
p) spectre
q) parleys
r) stress
s) Internet
t) totally unacceptable

1 Pharmacist..... by dispensing doctors
2 Dobson..... Labour health team
3 Pharmacists under.....
4 EPIC to discuss union or.....
5 PRS..... to make Health Plus pay
6 NI CPPET to..... through pharmacy press
7 '.....' now plague 42pc of pharmacies
8 Labour to..... firms for late debt payments
9 Government '.....' pharmacy
10 LPC secretary ..... in Downing Street
11 No dissent on ..... in working hours
12 Stock shortage ..... looms large
13 Generics firms question '.....' deals
14 Pharmacists go ..... at 30?
15 PSNC ..... 'good value'
16 DoH's 2.3pc offer '.....', says PSNC
17 MCA on the trail of the '..... law breakers'
18 NPA asks MCA for ..... clarification
19 Asda calls off .....
20 ..... vision for the New Year

B: Catchy ad slogans

Match the advertising slogan with what was being advertised:

1 Treat cold sores at face value

2 Shelf-confidence. Pain relief without the pills

3 Pharmacists turn $s into lbs

4 Whose vision of the future is built on leading brands of today?

5 Unique protection for the sun sensitive

6 Relief has arrived

7 One man and his dog win gold in New York

8 We will always be there, we will always care

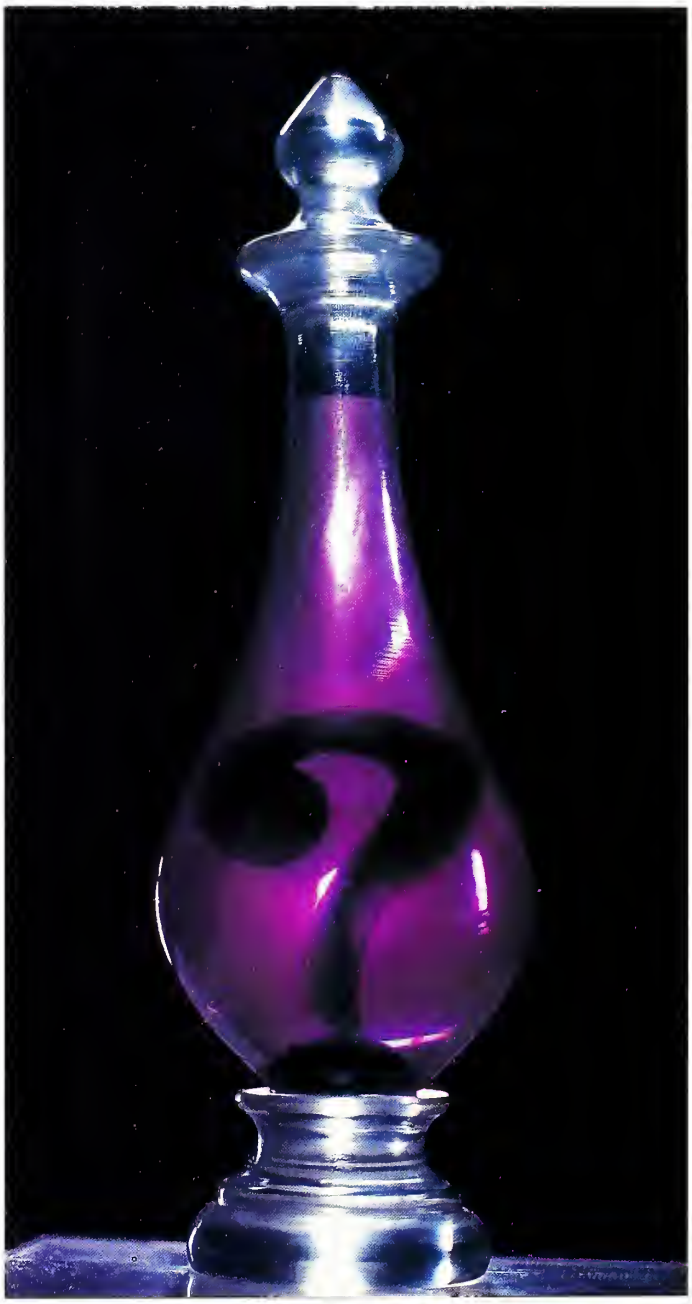
9 .....for travellers who don't travel well

10 The new face for migraine relief

11 ..... for pinpointing, penetrating and powering away the pain

12 Thwart that wart

13 Generic Engineering



3D sculpture: Paul Dennis. Photograph: Ryan Davies

14 ..... Medicine not to be taken lightly

15 Helps stop tension headaches fast

16 Psoriasis movers

17 They gain, you gain

18 Helping to keep your customers regular

19 ..... brings you back

20 Even your coolest customers will itch for.....

C: Shindigs

1 Match the company or organisation whose conferences, covered by *C&D*, took place in:

a) Bromsgrove .....
b) Scarborough .....
c) Budapest..... *and* .....
d) Malta .....
e) Vancouver .....

f) Bahamas ..... *and* .....

2 Where is BPC in 1998 .... and when? .....

3 Who won the overall BPSA/PMI sports weekend and where? ..... *at* .....

4 Whose conference theme was 'Mission? Impossible!' this autumn? .....

D: Serious stuff

1 What will the Guild of Hospital Pharmacist initials GHP stand for after January 23, 1998?

.....

2 What gained a $250,000 boost from the health secretary, having replaced 'stickiness and bendiness' ?

.....

3 Who was the first pharmacist to obtain CPP membership by practice?

.....

4 Who was the richest pharmacist in the UK, according to *The Sunday Times* Rich List published in April 1997, with an estimated fortune of $275 million?

.....

5 Who were the three new faces elected onto the RPSGB Council in May?

.....

6 Where is an award winning Hills pharmacy half buried (under soil, not paperwork)?

Philip Bier Photography

.....

7 Which health authority announced in May that it was putting homoeopathic referrals on hold?

8 Where did health secretary Frank Dobson first publicly announce the setting up of Health Action Zones?

.....

9 To which association did the RPSGB write, following an apparent endorsement in the association's newsletter of a candidate in the Society's Council elections?

.....

10 Which debate did the NPA aim to re-open in its response to the RPSGB's 'New Horizon' document?

.....

11 Which enlarged company was sent to Coventry, in a manner of speaking?

.....

12 Who is leading the review of prescribing, supply and administration of medicines for NHSE?

.....

13 Defence of what, has been specifically excluded by the NPA Board from insurance cover offered by the CDA?

.....

14 The School of Pharmacy at Brighton University announced in September it was developing an immunisation process against addiction to which substance?

.....

15 Hadley Hutt and Chemtec where acquired by which company in September?

.....

16 A consumer advice line dealing with common ailments with the acronym CHC has been set up by which group?

.....

17 Which judge strengthened the Cripps Causeway ruling this summer in defining what might – legally speaking – be considered a neighbourhood?

.....

18 Which pharmacy was the overall winner of this year's Switch Independent Retailer Excellence Awards?

.....

19 Who's new suede shoes are under Unichem's directors' table as chairman?

.....

20 Over the classification of which chemical entity has Pharma Nord been granted leave to appeal?

E: Numbers

a) What membership target did Nucare announce in April for the year 2000?

.....

b) What level of Numark membership was reported to have been passed in April?

.....

c) How many pharmacy assistants had passed and received their Cambridge Counterpart Course certificates by the end of September?

.....

d) At what value was Lloyds Chemists placed in Gehe's successful take-over bid?

.....

e) How many pharmacies were registered in Great Britain at the end of 1996?

.....

f) Which anniversary is TCP celebrating this winter?

.....

g) Who failed by one to complete a century of Branch visits as a Council member in October?

.....

h) What percentage increase on the global sum for contractors in England and Wales was the last remuneration offer put forward by the Conservatives?

.....

i) What figure was the estimated annual value of prescription fraud given by the NHS Executive when health minister Alan Milburn unveiled measures to fight the problem in June?

.....

j) The oldest pharmaceutical golf club in the world celebrated its centenary in June. Which is it?

F: Wheat from the chaff

1 What is the name of the tenor singing in the Benylin advert?

.....

2 What is the name of the TCP gargling horse?

.....

3 Which "cleaner" pharmacists have managed to become a Trivial Pursuit question and why?

.....

4 How much did the Science Museum pay for a sample of the original *Penicillium* culture used by Sir Alexander Fleming in his work on antibiotics

5 Former news reader Jan Leeming was at Chemex promoting which products?

.....

6 EPIC chairman Bob Gartside is also a director of which restorative association?

.....

7 Whose pins are these (above) and why are they so togged?

G: Speculative

The final section of questions may be speculative (and doesn't count in the quiz proper), but if you know the answers we may be contacting you for the news pages.

- When will the next Pharmacy Week be held?
- By what name will Lloyds/Hill be known in two years time?
- On which date will the DoH approve the electronic transfer of prescriptions (to the nearest month/year)?
- When will the Government next give an above inflation pay award to pharmacy?

- Caption the picture above of a well known editor in the most amusing (and least libellous) way (the subject will be asked to be the final arbiter).

Focus on the positive

I was not surprised by **Xrayser**'s comments (*C&D* November 29) regarding the Nicorette Inhalator. I would expect the same concern from any pharmacist on the introduction of a medicine with the potential to be misused. In general his philosophy is correct, but I am convinced that in respect of nicotine replacement therapy it is, and always has been, misplaced.

NRT is a medicine, but is unique as it is designed to reduce 'symptoms' experienced when stopping smoking. NRT is, as its product licence indicates, designed for smoking cessation rather than smoking reduction. **Xrayser** will know this is a difficult outcome to achieve, certainly at a first try. When using NRT, counselling and advice from the pharmacist will improve the chance of stopping completely, but we seem to be doing a disservice to those who are heavily nicotine dependent.

Xrayser focuses on the negative – the potential for NRT to be misused. Perhaps we should focus more on the positive – the considerable health gains from NRT in place of smoking. The product licence for NRT is for three months use, yet after three months do we put a ban on ex-smokers using NRT and so force them back onto cigarettes?

This to me seems irrational. I have seen no evidence that long-term use of NRT is detrimental to health, but every schoolchild knows the health risks of smoking. Before I am accused of suggesting that we replace cigarette smoking with NRT use, perhaps we might give some thought to the health gain from this.

As healthcare professionals let us keep our goal fixed on the health gains that will be achieved by reducing smoking, while supporting total cessation as our preferred outcome. I welcome this new device which adds further to the help pharmacists can give to smokers, and I hope that pharmacists will add their weight to reducing deaths from smoking.

Terry Maguire
Belfast

NRT unlikely to encourage dependence

I write in response to the recent **Xrayser** article (*C&D* November 29) on nicotine replacement therapy and would like to reassure the author on the relative safety of this type of treatment.

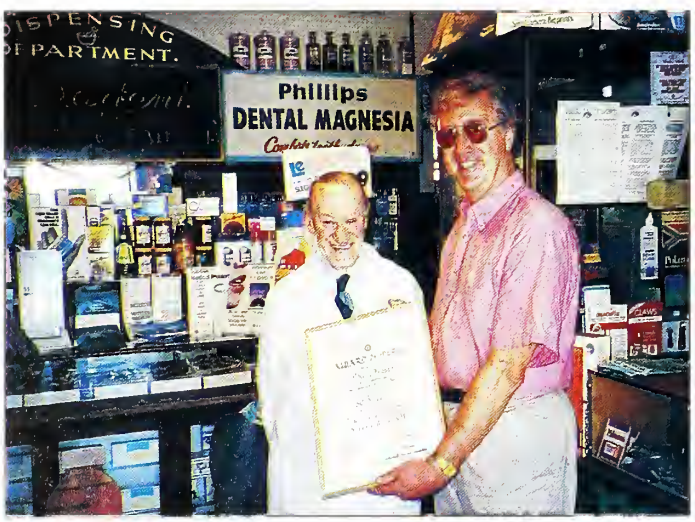
Unlike cigarettes, NRT does not produce rapid, high arterial plasma nicotine concentrations following use. Therefore, it is highly unlikely it will encourage dependence or abuse. It simply does not offer the same effect.

Safety is arguably the greatest concern when granting product licences, and the evidence in support of NRT is so overwhelmingly favourable that it has been a Pharmacy product for many years. Moreover, any potential health risk associated with long term NRT usage pales into insignificance compared to the harm caused by smoking tobacco.

We are pleased that **Xrayser** feels that Pharmacia & Upjohn has supported his needs for continuing education. Our recent training modules in *C&D* and the Tutorial (*C&D* December 6) support our case, and should bring pharmacists and their assistants to a point where they can recommend NRT, including the Nicorette Inhalator, with confidence.

It goes without saying that we should all be working together, in every way possible, to help those who wish to stop smoking. In this regard, what better way to support smokers in their efforts to quit, than offer them a range of nicotine replacement therapies to match the individual's particular needs?

Rob Whitemore
General manager, consumer healthcare, Pharmacia & Upjohn



During a recent visit to Camps Bay, just outside Cape Town in South Africa, Patrick Foster, managing director of Novartis Consumer Health in the UK, found himself drawn to a quaint old pharmacy open on a Sunday morning. Inside he was welcomed by the owner, Patrick Isaacs. The real surprise came when Mr Isaacs announced he was 92 years old. He started his apprenticeship in 1922 and has been practising 75 years. He opens his pharmacy seven days a week and still does his own dispensing. Is Mr Isaacs the oldest practising pharmacist in the world? wonders Mr Foster ...

Emergency contraception – a misconception!

In reporting the project proposed by Dr Keith Holden (*C&D* December 6, p4), *C&D* is guilty of perpetuating a common 'misconception' in using the term 'the morning after pill'.

Research has shown that only 33 per cent of people are aware of the correct time scale for emergency contraception. Ninety three per cent of women requesting an abortion would have preferred using emergency contraception.

Buckinghamshire LPC is working with the Health Promotion Department of Buckinghamshire Health Authority to increase understanding among both potential users, youth workers, teachers and health professionals that emergency contraception can be used up to 72 hours after unprotected intercourse.

The role which pharmacists have to play in increasing the awareness of contraception has already been demonstrated by the success of the Pharmacy Healthcare Scheme leaflets and the window campaigns in Ealing Hammersmith and Hounslow.

Within Aylesbury, the LPC is working to develop this role as part of a multi-agency project to increase awareness of emergency contraception and local service provision. It is proposed that pharmacies will be displaying materials designed by the local youth groups and providing information and 'fast access cards' to enable appointments to be made within the 72 hours.

It is important that all pharmacists are encouraged to help remove the myth of the 'morning after pill'.

Angela Alexander
Secretary, Bucks LPC

Come on, get real!

Just exactly what are these local pharmaceutical committees, which are baying for a delay in the PSNC elections, trying to achieve?

Chemist contractors are all receiving less and less remuneration for more and more work. I am sure the vast majority will not agree to any waste of their hard-earned income on an 'all wind and water' special conference, which those who live in the real world know will not gain us one single penny more.

We have been told that there is no new money. Can contractors not understand this? Don't they realise that the Government will give us no more, whether we have the present PSNC or some new airy-fairy body?

There are two real problems facing community pharmacy today; the shortage of graduates and the surplus of dispensing contracts. Where are the genuine ideas from LPCs on these two subjects? All they appear to be able to do is to criticise our chairman!

All this grand rhetoric about future structure, composition and agenda is a futile attempt to mask the real truth. A vociferous and vocal minority keeps on braying about problems. One glance in the mirror will surely reveal all. Indeed, they are fast becoming proselytes to solipsism.

So come on, be real! If you think that you can get genuine support from the silent majority, please supply constructive and detailed ideas and plans that can be promulgated to develop a successful solution to these two problems.

David Thomas
Wolverhampton

Peter Black buys Ferrosan

Peter Black Holdings has reaffirmed its intention to be a major player in the £300 million plus retail vitamins, minerals and supplements (VMS) market, by acquiring Ferrosan (UK) for around £35m.

The deal means Peter Black, which already owns Gerard House and English Grains, is now challenging Roche Products for the number two position in the VMS sector, behind Seven Seas (Euromonitor).

The two businesses will have a combined annual turnover of around £44m.

Ferrosan controls the Healthcrafts range, smaller niche brands such as Seatone and Superted, and markets a range of licensed herbal remedies under the Heath & Heather banner. It also supplies a number of the multiple retailers with own-label ranges and has a mail order division which operates the Nature's Best and Lamberts catalogues.

Ferrosan is expected to report a 30 per cent rise in pre-tax profits to around £3m, on a turnover up 10 per cent at £22m for the year ending December 31 1997.

Peter Black's divisional operations director Bruce Leworthy says the UK market for VMS products has grown consistently and is worth as much as £330m per year at retail.

"Pharmacies account for around 20 per cent of our business but customers will not see any radical changes in the short term. However, both companies have strong brands which will be supported by a significant investment in marketing and promotion in the medium term," he says.

Mr Leworthy said he could not confirm if any rationalisation, including staff redundancies, will be necessary until the integration process has been completed. Ferrosan's three managing directors Michael Evans, John Redman and Anthony Bush will remain at the company, however.

The maximum consideration of £35m paid to Ferrosan A/S of Denmark for its UK arm will be funded by the placing of five million new Peter Black ordinary shares with the balance financed out of existing cash resources and new borrowing.

DTI backs Pfizer's £108m expansion plans

Pfizer has won full Government backing to develop its UK healthcare research centre at Sandwich in Kent.

The US pharmaceutical giant has received a £3 million grant from the Department of Trade & Industry and a £2.5m contribution from English Partnerships towards the cost of building the £108m facility.

Since 1990, the company has invested £480m in the R&D centre which has developed a number of important medicines. These include the cardiovascular treatment Istin (Norvasc); the fungal infection drug Diflucan and Cardura for hypertension and benign prostatic hyperplasia.

Sales of these drugs will exceed $3.5bn ($2.2bn) this year and contribute around 40 per cent of the company's global human prescription medicine turnover.

"The significant investment in new research facilities will reinforce our efforts to discover innovative new medicines which will address the medical needs of the 21st century," says Dr Simon Campbell, senior vice-president for Pfizer's R&D Europe and Worldwide Discovery.

Work on the 500,000 sq ft research complex will begin in February and take two years to complete. Around 1,000 jobs will be created.

- The Pfizer announcement came in the same week that Zeneca Pharmaceuticals announced it was adding two manufacturing plants at its Bristol site. The investment of £9.1m will supplement existing bulk drug manufacturing capacity for Accolate, the oral treatment for asthma, and Seroquel, the company's antipsychotic agent for the treatment of schizophrenia.

Glaxo looks to increase R&D success rate

Glaxo Wellcome said it expects 18 new chemical entities (NCEs) to have entered exploratory development during 1997.

This compares with a total of only six NCEs by the two companies in 1994 and emphasises the group's intention to increase the proportion of medicines that ultimately reach the market.

Speaking to investors and analysts at G-W's medical research centre in Stevenage, worldwide R&D director Dr James Neidel said only four of the 28 NCEs that have entered development in the past two years have been dropped.

"The industry would have expected to see a third fall out of the pipeline at this stage of development. These figures show that we are on our way to achieving our goal of delivering three significant medicines a year," he said.

He added that industry statistics show only 10 per cent of compounds that enter development subsequently achieve registration by regulatory authorities.

"Glaxo Wellcome will improve this ratio through better selection of candidate drugs and targets for new medicines, as well as improved product development," said Dr Niedel.

- G-W has settled litigation in Spain on patents covering ranitidine and ranitidine hydrochloride, the active ingredient in its anti-ulcer drug Zantac. Under the agreement, Holliday Chemical Holdings' subsidiary Uquifa will pay $9m to G-W in exchange for a licence to manufacture the ingredients for supply outside Europe.

Astra Merck and Procter & Gamble to develop OTC Prilosec in US

Astra Merck and Procter & Gamble have joined forces to develop and market an OTC version of the antisecretory drug Prilosec (omeprazole) in the US.

The two companies will develop the clinical support and other data needed to gain clearance by the Food and Drug Administration (FDA) to market the drug as a treatment for heartburn in the US.

The alliance is designed to maximise brand awareness for Prilosec before it begins to lose patent protection in 2001.

Procter & Gamble will take responsibility for marketing, sales and distribution, and it will pay upfront payments to Astra Merck, as well as royalties based on US net sales of the OTC version.

Omeprazole is already marketed in countries outside the US, including in the UK, under the brand name Losec.

Moves at the top of Novartis

After 15 years running the UK consumer health division of Ciba, and then Novartis, Patrick Foster has decided to take early retirement.

His successor is Godfrey Axten (below), who takes up the position of managing director/chief executive officer, Novartis Consumer Health UK on January 1.

Mr Axten relocates from Sweden, where he has been country general manager and regional director Nordic since 1996. He was with Ciba Self-Medication before the merger of Ciba and Sandoz, and he has also held positions within Warner Wellcome, Wellcome Consumer Health and Schering-Plough in the US.

Patrick Foster has agreed to take over Novartis' South African operation on a temporary basis to stabilise and grow the business, and to find a new managing director.

Ciba Consumer Health began life in 1983 when Mr Foster moved from being commercial director of Farleys (then owned by Glaxo). His brief was to grow the business by acquisition, licensing and product turnover. In 1997 the average weekly sales exceeded total annual sales for 1993.

Les Wood, director of sales and marketing, commented: "Our 1997 business performance reflects a 6 per cent growth year on year. The merger of Zyma (Ciba) and Intercare (Sandoz) has given Novartis a very positive start in its top five position in the UK OTC market."

Xenova forms joint venture

Xenova Discovery has formed a joint venture with EG&G Wallac of Finland to offer a combined R&D service to the pharmaceutical and biotechnology industries. The new company is called Advant and brings together Xenova's screening and informatics capabilities with EG&G's experience in instrumentation and labelling. Each company will license a number of their proprietary technologies to Advant.

Licences for Bioglan

Bioglan has received multiple registration in Europe for three of its products in just six months. Licences have been awarded for Glytrin, Crystacide and Micanol in 12 countries.

ABPI gets training boost

The Association of the British Pharmaceutical Industry (ABPI) has been granted National Training Organisation (NTO) status by the Government.

Boost for toiletry trends

More accurate consumer information on trends in the toiletries and healthcare market will soon be available from research company Taylor Nelson AGB. It has introduced a new weighting technique and updated its computer software to improve the analysis of its Superpanel Personal Care Service which samples 10,000 homes.

Award for 3M manager

Dr Ian Tansey, 3M Health Care's senior technical manager has been honoured for his work to replace CFCs in asthma inhalers. The US Environmental Protection Agency presented him with the Stratospheric Ozone Protection Award.

A third of chemists prosper

More than 30 per cent of retail chemists are economically strong while the financial position of more than 24 per cent is described as dangerous, according to the latest 'Plimsoll Portfolio Analysis'.

The study of the financial status of 292 retailers and wholesalers reveals that the industry, as a whole, grew by 8.1 per cent in the last year. One in five businesses increased their sales by more than 20 per cent, while 15 per cent made a loss in their last financial year.

Although profit margins averaged 3.1 per cent, one in five companies significantly out-performed the market and enjoyed a pre-tax profit return of more than 10 per cent.

The companies reporting the highest sales growth were Jumbogate (up 61 per cent), Strathclyde (up 27 per cent) and Waymade Healthcare (up 26 per cent).

Plimsoll says the retail chemist market is optimistic about the future because 40 per cent of firms increased their borrowing.

"Many have confidence in their business to take on extra liabilities in the expectation of reaping benefits in the future, while others are confident enough to put up their own money," says compiler Mark Haynes.

The analysis does reveal, however, that the financially strong companies reduced their loans by £469m while the weakest increased their overall borrowing by £240m.

"A sudden increase in borrowing should not be taken in isolation as a measure of a company's overall financial position. To get a clearer picture other factors such as sales growth, profitability, trading stability, immediate liquidity and working capital must also be considered," says Haynes

The report, 'Plimsoll Portfolio Analysis – Retail Chemists', costs £305 and is available from Plimsoll Publishing on 01642 230977.

EU demands same rights for part-timers

Part-time workers must be given the same rights as full-time staff, says the European Union.

A Directive agreed last week means that anyone working fewer than 16 hours a week is entitled to equal pay, contractual terms and conditions of service, and training as well as share options, sick leave and staff discounts.

Each EU member state has two years to implement the Directive into domestic law. The agreement is the first EU social measure supported by Britain following the new Labour Government's decision to sign up to the Social Chapter of the 1992 Maastricht Treaty.

The announcement comes just two weeks after the Government published its minimum wage bill that promised to include part-timers in any new law.

The Government came under attack from opposition parties last week for ruling out regional variations when setting the minimum wage. The latest New Earnings Survey revealed that half as many people in the North East earn less than £3.50 an hour than in London.

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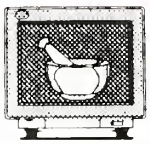

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*Source: Martin Hamblin Readership Survey

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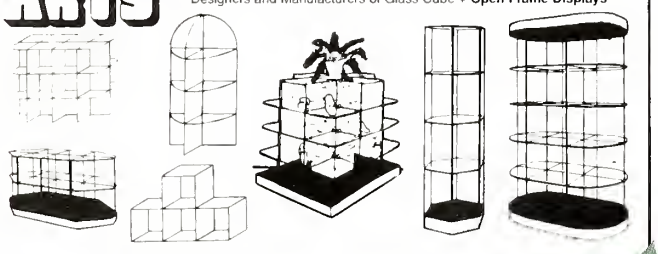

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ABOUTpeople

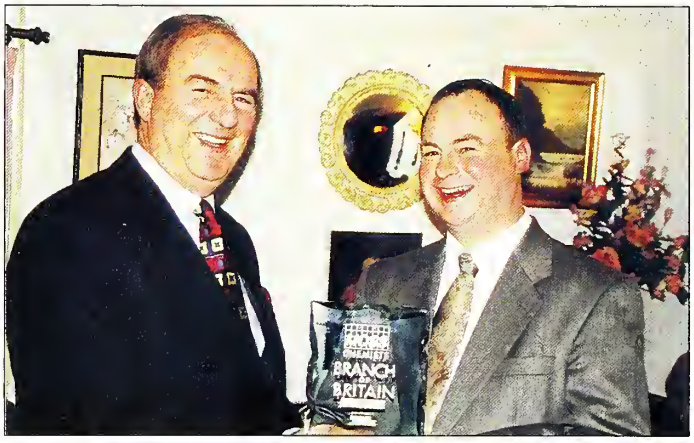
Moss selects top branch for 1997

Staff from Selles Dispensing Chemist in Sherburn-in-Elmet, near Leeds, enjoyed a gourmet dinner prize last month for winning Moss Chemists' 1997 'Branch of Britain' award.

As well as their meal at the Bon Viveur restaurant in Sherburn-in-Elmet with Moss Chemist's managing director Barry Andrews, the seven counter assistants and their branch manager each received £60 worth of Marks & Spencer's vouchers.

Over 500 Moss branches were assessed on presentation, customer service, training and compliance with promotions and stock levels. The 19 area winners produced an advert for one of sponsor Warner Lambert's products.

"It's a nice feeling to have won the award, but we weren't going for the prize as such. The best thing about us is we're a well-trained community pharmacy with friendly staff and friendly customers," says pharmacist manager Derek Swann.



Warner Lambert sales director, John Taylor, (left) is pictured presenting winning branch manager, Derek Swann, with a trophy

● This year Moss Chemists has raised £31,000 for its chosen charity, the Foundation for the Study of Infant Deaths, through the sale of pin badges and branch fundraising.

Underground pharmacy 'bricks' the mould

Chiddenbrook Pharmacy in Crediton, Devon, was the runner-up in the public and commercial category of the 1997 Brick Awards, held in Birmingham on November 24.

The underground pharmacy's roof is covered with meadow turf and wild flowers (*C&D* May 3, p34). Judges described the Hills pharmacy as a "very special small project almost deserving of its own category".

Architects Smith Roberts associates helped blend the pharmacy with its surroundings, by building it with the same materials that were used to build an adjacent surgery.

To qualify for the awards, a building must have been constructed within the past three years using a Brick Development Association's member's bricks.

Boots aids breast cancer charity

Boots The Chemist helped the charity Breast Cancer Care raise a £700,000 during its breast cancer awareness month in October. Over £150,000 came from the sale of pink ribbons on cards bearing the charity's helpline number and 250,000 leaflets were distributed.

A further £25,000 was raised by staff and volunteers, who collected donations. "As 80 per cent of our customers are women, we were in an ideal position to inform them how vital it is to be breast aware," says BTC's PR manager Janis Churton.

Proprietor pharmacist Anthony Chong and staff from the People's Pharmacy in Chelmsford, Essex, helped raise £350 for the BBC Children in Need appeal on November 21. This year's appeal raised £12 million – half the total of the record £25.6m raised in 1990. Pictured (l-r) are court jester Thelma Scott, pirate Anthony Chong, one-month-old baby Caera and queen of hearts Carole Barker

APPOINTMENTS

AAH Pharmaceuticals has appointed Unichem's former wholesale managing director, **Stephen May** (below) as sales director.

The newly elected committee of the Young Pharmacists' Group comprises **Wendy Harris** (chairman), **Alistair Buxton** (secretary) and **Sultan Dajani** (public relations officer). YPG has co-opted **Jahn Dad Khan** as vice-chairman; **Philip Kirkpatrick**, treasurer; **Joanne Goulding**, membership secretary; **Andrew Watson**, social secretary; **Ian Wold**, newsletter editor; **Sangeeta Prassad**, Midlands; **Catherine Terry**, Wales and West; and **Sharon Hart**, recruitment assistant.

RPSGB council member and chairman of Gateshead & South Tyneside Health Authority, **Bill Darling CBE**, has been appointed president of the International Hospital Federation.

Stewart Littlewood is to join pharmaceutical wholesaler A D Allen as export director from January 1.

L'Oréal UK has appointed **Valerie James** as its director of communications. **Nicolas Hieronimus** will take over her old role as general manager of Laboratoires Garnier.

Christelle Morris has joined Wahl Europe as a London and southern region junior sales executive.

Salford MP **Hazel Blears** has been appointed as parliamentary private secretary to Alan Milburn, Minister of State for Health.

Peter Cooke has been appointed vice-president of the Guild of Hospital Pharmacists, and **Gerry Wilson**, the GHP's new treasurer. **Ron Pate** has become chairman of the GHP's terms & conditions committee.

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GOOD COD IT'S AMAZING!

The active ingredients, Omega 3 fatty acids, found in Seven Seas cod liver oil have a vital role in the healthy maintenance and function of the body, they can also help improve health, protect against some degenerative diseases and relieve inflammatory conditions such as arthritis.

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A decline in the intake of Omega 3 in today's diet is a particular cause of concern. While dietary Omega 6 has risen, Omega 3 has fallen. Many researchers believe that most people need extra fish oils fat to balance the family of fat nutrients.

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Fish oils contain the rare Omega 3 long chain polyunsaturated fatty acids (PUFA). Found exclusively in foods of marine origin, the natural active Omega 3 nutrients are known to help form cell membranes and control vital metabolic processes whilst having anti-thrombotic and anti-inflammatory effects. This means that taking a cod liver oil supplement containing the active ingredient Omega 3 in its highest strength is particularly beneficial to helping maintain a healthy heart and relieving joint pain and stiffness.

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To relieve joint pains and muscular stiffness associated with arthritis.	☑	
For a fit and healthy body.		☑
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KEY: ☑ Highly recommended

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for those who require the maximum dosage of Omega 3 in capsules

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Seven Seas comments 'Arthritis and painful joints affect more than 20 million people in Britain and this figure will grow as the population ages. Dietary measures can produce considerable improvement and studies have shown that cod liver oil helps reduce pain, tenderness and stiffness and improve mobility. In more severe cases, taking Seven Seas Extra High Strength Pure Cod Liver Oil daily can allow changes in the level of conventional therapy and, as a consequence, a reduction in side effects.'

For further information on the additional products in the Seven Seas range, please contact:
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